MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 25 (4/1/2023-3/31/2024)
Federal Fiscal Quarter: 4 (7/1/2023-9/30/2023)

I. Introduction

In July 1997, New York State (NYS) 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.
- 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.

The NYS 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, NYS 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 eligible to stay in MMMC 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 2023

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	**465,482**	**5,697**	**26,175**
Population 2 – TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06	**64,347**	**1,270**	**4,769**
Population 3 – TANF Child 1 – 20 ('new' MC Enrollment)	**6,658**	**101**	**745**

Population 4 – TANF Adults 21 – 64 ('new' MC Enrollment)	**37,209**	**517**	**2,615**
Population 5 – Safety Net Adults	**237,399**	**6,072**	**23,449**
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)	**156,749**	**1,410**	**106**
Population 9 – Disabled Adults and Children 0 – 64 ('new' MC enrollment)	**59,751**	**2,998**	**290**
Population 10 – Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**82,127**	**453**	**70**
Population 11 – Aged or Disabled Elderly ('new' MC enrollment)	**14,725**	**2,407**	**240**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollment's in Current Demonstration Year	**20,925 or an approximate 24.5% 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 (NYSoH). 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 a decrease in both "Code 97 Moved" and the "Undetermined" category of disenrollment. Undetermined refers to cases where a manual review would be needed to determine the specific reason for disenrollment.

Involuntary Disenrollments	
Total # Involuntary Disenrollment's in Current Demonstration Year	**58,459 or an approximate 31.4% decrease from last Q**

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

WMS continues to send select closed cases to NYSoH. Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to an overall general decline in involuntary disenrollment.

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

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
July 2023				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**763,787**	**19,079**	**3,835**	**15,244**
Rest of State	**301,337**	**9,492**	**940**	**8,552**
Statewide	**1,065,124**	**28,571**	**4,775**	**23,796**
August 2023				
New York City	**767,830**	**22,447**	**4,745**	**17,702**
Rest of State	**293,974**	**11,048**	**1,155**	**9,893**
Statewide	**1,061,804**	**33,495**	**5,900**	**27,595**
September 2023				
New York City	**773,743**	**20,811**	**3,635**	**17,176**
Rest of State	**288,062**	**12,130**	**1,394**	**10,736**
Statewide	**1,061,805**	**32,941**	**5,029**	**27,912**

Fourth Quarter	
Region	**Total Affirmative Choices**
New York City	**50,122**
Rest of State	**29,181**
Statewide	**79,303**

HIV SNP Plans				
July 2023				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**13,155**	**202**	**0**	**202**
Rest of State	**20**	**1**	**0**	**1**
Statewide	**13,175**	**203**	**0**	**203**
August 2023				
New York City	**13,163**	**199**	**0**	**199**
Rest of State	**19**	**0**	**0**	**0**
Statewide	**13,182**	**199**	**0**	**199**
September 2023				
New York City	**13,207**	**203**	**0**	**203**
Rest of State	**19**	**0**	**0**	**0**
Statewide	**13,226**	**203**	**0**	**203**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**604**			
Rest of State	**1**			
Statewide	**605**			

Health and Recovery Plans Disenrollment			
FFY 23 – Q4			
	Voluntary	**Involuntary**	**Total**
July 2023	**522**	**4,093**	**4,615**
August 2023	**700**	**2, 058**	**2,758**
September 2023	**553**	**1,859**	**2,412**
Total:	**1,775**	**8,010**	**9,785**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 4 (7/1/2023-9/30/2023) Q4 FFY 2023

As of the end of the fourth federal fiscal quarter (end of September 2023), there were 3,006,801 New York City Medicaid consumers enrolled in MMMC Program and 76,092 Medicaid consumers enrolled in HARP. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 31 HRA facilities including 6 HIV/AIDS Services Administration (HASA) sites, 9 Community Medicaid Offices (MA Only), and 16 HRA Benefits Access Centers (Public Assistance). MAXIMUS reported that 3,458 clients were educated about enrollment options and made an enrollment choice including 577 clients in person and 2,881 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. During the reporting period, 82 Enrollment Counselling sessions were evaluated which generated two applications for a total of two enrollments.

CMU Monitoring of Field Presentation Report – 4th Quarter 2023	
Enrollment Counseling – One on One	General Information
82	80

Of the two enrollments completed during informational sessions, two (100%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

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 27,760 FFS community clients were reported on the regular auto-assignment list, 6,499 clients responded to the call that generated 3,261 enrollments. Of the total of 38 FFS NH clients reported on NH auto-assignment list, 3 (8%) clients and/or authorized representatives made a Plan selection. CMU monitored 784 outreach calls by FCSRs in HRA facilities. The following captures those observations:

Phone Enrollment Applications			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
429	0	429	355	0	355

- Phone Enrollment Applications: 429 (55%) FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 599 enrollments.
    - 588 (98%) enrollments were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 355 (45%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

C. NYMC HelpLine Observations July 2023- September 2023

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 **45,179** calls were received by the Helpline and **44,381** or **98%** were answered. Calls answered were handled in the following languages: **English: 27,697 (62%); Spanish: 6,217 (14%); Chinese: 1,763 (4%); Russian: 1,229 (3%); Creole: 102 (1%); and other: 7,373 (16%).**

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to **5,027** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 4th Quarter 2023								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
2,935 (58%)	**502 (10%)**	**391 (8%)**	**1,142 (23%)**	**54 (1%)**	**0 (0%)**	**3 (0%)**	**0 (0%)**	**5,027**

A total of **1,706 (34%)** recorded calls observed were unsatisfactory. 1,144 calls had a single infraction and **562** calls had multiple infractions. A total of **2,318** infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,804 (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: **163 (7%)** – CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of primary care provider (PCP); and referrals for specialists.
- Customer Service: **351 (15%)** – Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **2,318** corrective action plans (CAP) 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

NYMC Field Observations Federal Fiscal Year 2023 (10/1/2022-9/30/2023)
As of the end of the federal fiscal year 2023 (end of September 2023), there were 3,006,801 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 76,092 Medicaid consumers enrolled in HARP. MAXIMUS, the Enrollment Broker for the NYMC, conducted in person outreach, education, and enrollment activities in HRA facilities throughout the five boroughs of New York City.

During the reported period MAXIMUS FCSR's conducted personal and phone outreach in 15 HRA facilities open to the public. MAXIMUS reported that 26,803 clients were educated about enrollment options and made an enrollment choice including 1,843 clients in person and 24,960 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 had been suspended since 3/23/2020 due to the pandemic and was restored in May 2023. During the reporting period, 168 enrollment counseling sessions were evaluated which generated four applications for a total of four enrollments.

CMU Monitoring of Field Presentation Report – October 2022-September 2023	
Enrollment Counseling – One on One	General Information
168	164

Of the four enrollments completed during informational sessions, four (100%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

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 NH clients identified for plan auto-assignment. A total of 114,629 FFS community clients was reported on the regular auto-assignment list, 25,867 (9%) clients

responded to the call that generated 13,338 enrollments. Of the total of 201 FFS NH clients reported on NH auto-assignment list, 8 (4%) clients and/or authorized representatives made a plan selection. CMU monitored 1,354 outreach calls by FCSRs in HRA facilities. The following captures those observations:

Phone Enrollment Applications			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
734	0	734	617	3	620

- Phone Enrollment Applications: 734 (54%) FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 995 enrollments.
    - 893 (90%) enrollments were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 620 (46%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

NYMC HelpLine Observations October 2022 to September 2023

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 189,862 calls were received by the Helpline and 185,940 or 98% were answered. Calls answered were handled in the following languages: English: 120,033 (65%); Spanish: 25,034 (13%); Chinese:7,607 (4%); Russian: 4,685 (2%); Haitian/Creole: 295 (1%); and other: 28,286 (15%).

MAXIMUS recorded 100% of the calls received by the NYMC HelpLine 10/1/2022 through 9/30/2023. CMU listened to 19,699 recorded calls for the same period. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – October 2022-September 2023								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
11,059 (56%)	**1,801 (9%)**	**1,330 (7%)**	**5,243 (27%)**	**249 (1%)**	**0 (0%)**	**16 (0%)**	**2 (0%)**	**19,699**

A total of 5,605 (28%) recorded calls observed was unsatisfactory including 2,857 calls with single infraction and 2,370 calls with multiple infractions. A total of 8,307 infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: 6,615 (80%)- 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: 770 (9%)- CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, how referrals for a specialist works.
- Customer Service: 922 (11%)- Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 8,307 CAPs 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

- HealthFirst PHSP applied to provide services to members eligible for participation in the Integrated Benefit for the Dually Eligible program in Suffolk County.
- Highmark Western and Northeastern New York, Inc. applied to provide services to members eligible for participation in the HARP program in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming
- Molina Healthcare of New York, Inc. applied to provide services to members eligible for participation in the Integrated Benefit for the Dually Eligible program in the following counties: Bronx, Kings, Nassau, Queens, and Westchester.
- Capital District Physicians Health Plan notified the D they would be withdrawing from the following counties applicable to the Medicaid and HARP lines of business: Broome, Chenango, Clinton, and Delaware.

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

On March 4, 2022, NYS submitted to CMS amendment #2 to the March 1, 2019, Model Contract that includes contract provisions related to State Directed Payments. On March 31, 2022, this amendment was issued to 15 MCOs for signature. At the close of FFY 2022-2023, all 15 contracts have been executed by NYS and submitted to CMS for final approval.

C. Health Plans/Changes to Certificates of Authority

Effective August 2, 2023, MetroPlus Health Plan HIV-SNP was certified to provide services to the HIV-SNP population in Richmond County.

Effective July 1, 2023, MVP Health Plan was certified to provide services to for the Medicaid, Child Health Plus, and HARP eligible members in the following counties: Clinton, Essex, Franklin, Fulton, Hamilton, Herkimer, Montgomery, and St. Lawrence.

Effective July 26, 2023, Highmark Western and Northeastern New York, Inc. was certified to provide HARP services for eligible enrollees in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming.

- The DOH updated the Certificate of Authority to reflect HealthFirst PHSP, Inc is certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Bronx, Kings, Nassau, New York, Orange Queens, Richmond, Sullivan, and Westchester. Effective December 9, 2022.
- The DOH updated the Certificate of Authority to reflect HealthFirst PHSP, Inc is certified to provide Integrated Benefits for Dually Eligible Enrollees in Suffolk County. Effective May 11, 2023.
- The DOH updated the Certificate of Authority for New York Quality Healthcare Corporation to reflect the approved Medicaid Advantage Plus (MAP) expansion counties of Nassau, Suffolk, and Westchester. Additionally, the update also reflects removal of the Medicaid Advantage (MA) Line of Business, and two new DBAs, WellCare by Fidelis Care and WellCare. Effective February 16, 2023.
- The DOH updated the Certificate of Authority to reflect that Molina Healthcare of New York is certified to certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, and Westchester. Effective March 30, 2023.
- The DOH updated the Certificate of Authority to reflect that MetroPlus Health Plan, Inc. HIV/SNP is certified to provide HIV-SNP services to eligible enrollees in Richmond County. Effective August 2, 2023.
- The DOH updated the Certificate of Authority to reflect that MVP Health Plan is certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Albany, Columbia, Dutchess, Greene, Monroe, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, and Westchester. Additionally, the Certificate of Authority was updated to reflect the approval of a service area expansion for the provision of services for the Medicaid, Child Health Plus, and HARP eligible members in the following counties: Clinton, Essex, Franklin, Fulton, Hamilton, Herkimer, Montgomery, and St. Lawrence. Effective July, 1 2023
- The DOH updated the Certificate of Authority to reflect that Capital District Physician's Health Plan is no longer certified to provide services to Medicaid, Child Health Plus, and HARP eligible members in the following counties: Broome, Essex, Franklin, and Tioga. Effective August 1, 2023.
- The Department updated the Certificate of Authority to reflect that Highmark Western and Northeastern New York, Inc. is certified to provide HARP services for eligible enrollees in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming. Effective July 26, 2023.

D. CMS Certifications Processed

The following plans had State Certifications issued in 2023: Emblem, United Healthcare, and VNS.

E. Surveillance Activities

CMS Reporting FFY 2022-2023
Surveillance activity completed during the 1st quarter FFY 2022-2023 (October 1-December 31,2022) include the following:

Two Targeted Operational Surveys were completed during 1st Quarter FFY 2022-2023.
- Highmark- One SOD was issued and one POC was accepted.
- Amida Care- Plan found to be in compliance.

Surveillance activity completed during the 2nd Quarter FFY 2022-2023 (January 1, 2023-March 31,2023) include the following:

One Target Survey was completed during 2nd Quarter FFY 2022-2023. The Plan was found in compliance.
- MetroPlus-Plan found in compliance.

Surveillance activity completed during the 3rd Quarter FFY 2022-2023 (April 1, 2023-June 30, 2023) includes the following:

Three Comprehensive Operational Surveys were completed during 3rd Quarter FFY 2022-2023. An SOD was issued and a POC was accepted for two Plans:
- Healthfirst
- Molina

One Plan was found in Compliance:
- Excellus

Surveillance activity completed during the 4th Quarter FFY 2022-2023 (July 1,2023-September 30,2023) include the following:

No Survey activity to report.

No Operational POCs accepted, or EQRO POCs accepted for the purposes of this report.

V. Waiver Deliverable

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during FY2023. Final reports were previously submitted for all reviews except the one involved in an open legal matter.

- MEQC 2008 – Applications Forwarded to LDSS Offices by Enrollment Facilitators
  No activities were conducted due to a legal matter that is still open.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance

The final summary report was forwarded to the regional CMS office and CMS Central Office on July 1, 2015.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability
  The final summary report was forwarded to the regional CMS office on January 31, 2014, and CMS Central Office on December 3, 2014.

- MEQC 2011 – Review of Medicaid Self Employment Calculations
  The final summary report was forwarded to the regional CMS office on June 28, 2013, and CMS Central Office on December 3, 2014.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications
  The final summary report was forwarded to the regional CMS office on July 25, 2013, and CMS Central Office on December 3, 2014.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding
  The final summary report was forwarded to the regional CMS office on August 1, 2014, and CMS Central Office on December 3, 2014.

B. Benefit Changes/Other Program Changes

Transition of Behavioral Health (BH) Services into Managed Care and Development of Health and Recovery Plans (HARPs):

In October 2015 NYS began transitioning the full Medicaid BH system to managed care. The goal is to create a fully integrated behavioral health [mental health (MH) and substance use disorder (SUD)] 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 BH HCBS. For MMC, all Medicaid-funded BH services for adults, except for services in Community Residences, are part of the benefit package.

As part of the transition, the NYS DOH began phasing in enrollment of current MMC enrollees throughout NYS 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 FY 2018, NYS engaged in multiple activities to enhance access to BH services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the NYSoH. 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 (SDE) 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).

Effective April 1, 2023, the Medicaid pharmacy benefit was carved out of MMC to Medicaid FFS. Medicaid members enrolled in Mainstream MCOs, HARPs, and HIV SNPs now receive pharmacy benefits through the Medicaid FFS pharmacy program, NYRx. MMC Plans began sending notices to members and their providers about the Pharmacy benefit transition in 2022. Transitioning the pharmacy benefit from MMC to FFS provides NYS visibility into prescription drug costs, allows benefit centralization, and provides a single drug formulary with standardized utilization management protocols, simplifying and streamlining the drug benefit for Medicaid members.

Office of Mental Health (OMH) providers received notice that the Public Health Emergency (PHE) would expire on May 11, 2023. The notice detailed flexibilities afforded to providers regarding minimum billing standards and documentation requirements coming to an end, unless otherwise specified by OMH through formal regulatory waivers. Areas impacted by the end of the PHE include telehealth, documentation, utilization review, billing standards, Health Insurance Portability and Accountability Act (HIPAA) enforcement, hospital conditions of participants, and program specific guidance for community-based services and residential services.

Additionally, NYS resumed annual Medicaid recertifications in April 2023, having paused since March 2020 due to the federal PHE.

On June 29, 2023, NYS received approval from CMS for the Crisis Intervention State Plan Amendment (SPA) #22-0026. NYS intends to formally implement Mobile Crisis and Crisis Residence program and billing changes to effectuate the Crisis Intervention SPA.

The Crisis Intervention SPA consolidates and aligns Medicaid authority, coverage, and reimbursement policies for existing children and adults Mobile Crisis and Crisis Residence services. The Crisis Intervention SPA also authorizes coverage of Crisis Stabilization Center services.

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

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

NYS MH & SUD authorization requests and denials for Inpatient (4/1/2023-6/30/2023)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	32,784	165	148	0.45%
ROS	2,949	47	46	1.56%
Total	35,733	212	194	0.54%

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

NYS MH & SUD authorization requests and denials for Outpatient (4/1/2023-6/30/2023)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	3,974	80	29	0.73%
ROS	315	34	32	10.16%
Total	4,289	114	61	1.42%

***Due to data integrity issue, MetroPlus 2023 Q3 Outpatient authorizations and denials were not included.**

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

MH & SUD Claims (7/1/2023-9/30/2023)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,168,442	93.64%	6.36%
ROS	879,012	93.73%	6.27%
Totals	2,047,454	93.68%	6.32%

[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.

Behavioral Health Adults CORE/HCBS Claims/Encounters 7/1/2023-9/30/2023: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	239	65
Education Support Services	41	10
Family Support and Trainings	427	33
Intensive Supported Employment	31	12
Ongoing Supported Employment	3	1
Peer Support	2,578	581
Pre-vocational	47	7
Provider Travel Supplements	157	65
Psychosocial Rehab	4,342	590
Residential Supports Services	58	9
Transitional Employment	0	0
TOTAL	7,923	1,107

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 7/1/2023-9/30/2023: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	1,507	294
Education Support Services	108	37
Family Support and Trainings	551	46
Intensive Supported Employment	85	19
Ongoing Supported Employment	7	4
Peer Support	5,533	1,182
Pre-vocational	33	8
Provider Travel Supplements	5,147	1,174
Psychosocial Rehab	5,838	1,029
Residential Supports Services	692	118
Transitional Employment	0	0
TOTAL	19,501	2,336

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

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

NYS MH & SUD authorization requests and denials for Inpatient (7/1/2022-6/30/2023)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	132,853	729	668	0.50%
ROS	16,933	107	105	0.62%
Totals	149,786	836	773	0.52%

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

NYS MH & SUD authorization requests and denials for Outpatient (7/1/2022-6/30/2023)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	21,084	311	158	0.75%
ROS	991	102	100	10.09%
Totals	22,075	413	258	1.17%

***Due to data integrity issue, MetroPlus 2023 Q3 Outpatient authorizations and denials were not included.**

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

MH & SUD Claims (10/1/2022-9/30/2023)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	4,641,756	94.36%	5.64%
ROS	4,015,967	94.53%	5.47%
Totals	8,657,723	94.43%	5.57%

Behavioral Health Adults CORE/HCBS Claims/Encounters 10/1/2022-9/30/2023: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	915	109
Education Support Services	364	41
Family Support and Trainings	2,270	53
Intensive Supported Employment	344	33
Ongoing Supported Employment	34	4
Peer Support	18,233	1,080
Pre-vocational	254	18
Provider Travel Supplements	604	176
Psychosocial Rehab	20,468	1,158
Residential Supports Services	462	26
Short-term Crisis Respite	1	1
Transitional Employment	0	0
TOTAL	43,949	1,957

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 10/1/2022-9/30/2023: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	7,710	533
Education Support Services	1,045	115
Family Support and Trainings	2,407	71
Intensive Supported Employment	672	56
Ongoing Supported Employment	156	18
Peer Support	29,878	2,020
Pre-vocational	224	20
Provider Travel Supplements	24,417	1,932
Psychosocial Rehab	31,114	1,798
Residential Supports Services	4,415	219
Short-term Crisis Respite	0	0
Transitional Employment	0	0
TOTAL	102,038	3,810

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

Provider Technical Assistance

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 MCTAC.

Quarter 4 MCTAC Attendance & Statistics (7/1/2023 to 9/30/2023)

Events: MCTAC successfully executed **17** events from 7/1/2023 to 9/30/2023.
11 events were held via webinar and 6 were held in person.

Individual Participation/Attendance/Viewing of Resource:*(this includes all the individuals that attended the MCTAC offerings or viewed a resource online):*

2,677 people attended/participated in MCTAC events/viewed resources of which **1,912** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 295 of 721 **(40.92%)**

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: 159 of 434 **(36.64%)**

Annual MCTAC Attendance & Statistics (10/1/2022 to 9/30/2023)

Events: MCTAC successfully executed **80** events from 10/1/2023 to 9/30/2023.
74 were held via webinar and 6 were in-person.

Individual Participation/Attendance/Viewing of Resource:*(this includes all the individuals that attended the MCTAC offerings or viewed a resource online):*

11,728 people attended/participated in MCTAC events/viewed resources of which **5,880** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 467 of 721 **(64.77%)**

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: 271 of 434 **(62.44%)**

** *Please note, as of May 2023, MCTAC has included pre-recorded offerings in the total count of events.*

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, NYS 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, NYS 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.

To address the identified challenges, NYS made efforts to ramp up utilization and improve access to BH HCBS. NYS effectuated the following:

- Streamlined the BH HCBS assessment process.
    - Effective March 7, 2017, the full portion of the NYS 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 NYS can track in a Learning Management System.
- Implemented rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhanced 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 SDEs through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with SDE 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)
- Continued 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).
- Continued 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.
- Implemented 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.
- Disseminated consumer education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS OMH contracted with the New York Association Psychiatric Rehabilitation Services (NYAPRS) to conduct peer-focused outreach and training to possible eligible members for HARPs and Adult BH HCBS.
        - NYAPRS conducted outreach in two ways:
            - 45-90-minute training presentations delivered by peers.
            - 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. NYS worked with the MCOs on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS.
    - 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; NYS 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.
- Enhanced NYS 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, CMAs, and BH HCBS provider agencies. Developed and provided a variety of tools to support care manager referrals to BH HCBS, on behalf of the NYS Health Home/MCO Workgroup.
- Established a process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments. This was in response to challenges in securing a care management workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,324 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between July 1, 2023, and September 30, 2023, 756 eligibility assessments were completed.

Transition to Community Oriented Recovery and Empowerment Services

Despite the 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 remained 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, NYS released a draft proposal for public comment in June 2020 to transition 1115 Waiver BH HCBS into a State Adult Rehabilitation Services package, called CORE Services, for HARP enrollees and HARP eligible HIV-SNP enrollees. Public comment resulted in positive feedback, and NYS finalized the proposal and submitted to CMS in September 2020. Objectives of this transition were two-fold: to simplify and allow creativity in service delivery of community-based rehabilitation services tailored to the specific needs of the BH population, and to eliminate access barriers.

To receive the enhanced Federal Medical Assistance Percentage (eFMAP) available through the American Rescue Plan Act (ARPA), NYS revised the September 2020 proposal to comply with eFMAP requirements and resubmitted to CMS in July 2021. CMS approved NYS's 1115 Waiver Amendment Request for 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. Currently, all HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees can access CORE Services with a recommendation from a licensed practitioner of the healing arts (LPHA).

Enrollment in Health Home Care Management continues 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 MCOs and service providers.

CORE Services went live on February 1, 2022, for new and existing recipients (HARP enrollees and HARP-eligible HIV-SNP 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.

Consumer education materials are available on the OMH CORE website and were distributed via provider listserv. In January 2022, OMH participated in a Townhall series hosted by the Access 2 Recovery Coalition with a goal of educating HARP members about benefit changes.

NYS conducted a series of implementation trainings in partnership with MCTAC. After a transitional period of provisional designation and attestation, 115 providers received full designation for CORE Services. NYS 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 website.

In January 2023, in collaboration with NYAPRS, a CORE Peer Navigator Project was launched. This project is funded for two years through the Mental Health Block Grant, and focuses on outreach, education, and service navigation to support access to CORE and BH HCBS.

As of January 1, 2023, HARP-eligible MAP enrollees can also access CORE Services with an LPHA recommendation. NYS continues to provide technical assistance on this benefit carve-in. NYS provided MAP Plans with CORE Services guidance and training, in addition to MAP benefit package trainings for CORE Service providers and care managers.

NYS continues to consult CORE providers and MCOs to inform future guidelines around MCO responsibilities and oversight, such as utilization management of CORE Services. In August 2023, NYS held its first CORE Summit, a one-day training and networking event for CORE providers and MCOs. OMH and OASAS continue to provide education via trainings, conference presentations, and regional provider forums based on stakeholder feedback.

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, NYS 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. NYS will continue its efforts to increase access to behavioral health rehabilitation services through working collaboratively with Health Homes.

In addition, in 2021, NYS extended the Adult BH HCBS Infrastructure funding initiative to support BH providers transitioning the four services moving from BH HCBS to the new CORE Service array and continuing support of BH HCBS providers. OMH and OASAS distributed guidance for an Infrastructure Program Extension which allowed HARPs to contract for remaining, unspent funds totaling approximately $31.9 million. Based on a thorough network needs assessment, HARPs competitively awarded the funds to eligible providers. Infrastructure Program Extension contracts were executed between May and September 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 which account for 59% of all designated BH HCBS and CORE providers to support the transition to CORE Services and the continued provision of BH HCBS.
- Approximately $23.9 million in initial contract base awards and subsequent milestone payments were distributed to providers.
- The program is expected to conclude in July 2024.
- NYS developed an Infrastructure Program Extension dashboard which monitors BH HCBS, and CORE Service claims and unique recipients served by BH HCBS and CORE Service providers during the measurement period. The dashboard compares BH HCBS and CORE providers in Infrastructure Program Extension contracts with HARPs to those

not in Infrastructure Program Extension contracts. NYS solicited and incorporated feedback from HARPs on the development of the dashboard.

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

Based on stakeholder input and timing of other managed care initiatives, DOH has recently decided to amend the carve-in date for SBHC services into the MMC benefit package. The target implementation date has been changed to no sooner than April 1, 2024. No activity has occurred during this reporting period.

Annual: No activity has occurred during this entire reporting period.

C. Managed Long-Term Care Program (MLTCP)

MLTC 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, 2023, there are 22 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of October 1, 2023, there are a total of 324,826 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the July 2023 through September 2023 quarter, the DOH helped conduct the merger between 2 Partial Capitation plans.

During the annual period of October 2022 through September 2023, DOH approved service area expansions for three MAP, and two PACE plans. Two Partial Capitation plans merged on 10/1/2022, two Partial Capitation plans and two MAP plans merged on 12/1/2022, and two Partial Capitation plans merged on 8/1/2023.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For July 2023 through September 2023 quarter, post enrollment surveys were completed for seven enrollees. Of the seven surveyed, five of them (71%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. The percentage of affirmative responses is higher than the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased from 266,332 to 272,801 during the July 2023 through September 2023 quarter, a 2% increase from the last quarter. For that period, 14,723 individuals who were being transitioned into MLTC made an affirmative choice, an 7% increase from the previous quarter and brings the 12-month total for affirmative choice to 54,443.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the October 2022 through September 2023 quarter annual period is submitted as an attachment.

2. Significant Program Developments

During the July 2023 through September 2023 quarter:

- The 4th Quarter Member Services survey was conducted on 23 Partial Capitation Plans and 12 MAP Plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required, but, when necessary, DOH provided recommendations on areas of improvement.
- The Desk Review for four Partial Capitation Operational Surveys were completed and reported in prior reporting periods. The CAPs have all been approved by DOH.
- Operational Surveys are still open for two Partial Capitation plans that were reported in the prior reporting period, The Desk Reviews remain in progress.
- Two additional Operational Surveys were initiated for two Partial Capitation plans. The Desk Reviews are in progress.
- The follow up Focused Survey on all Partial Capitation and MAP Plans focusing on PCSP Template compliance that was reported in the prior reporting period has been completed. All Partial and MAP plans have been provided with DOH approval of their updated PCSP Templates.
- One Focused Survey was initiated on one Partial Capitation plan based on TAC Complaints (Rate Change). A Statement of Deficiency (SOD) was issued to the plan and the CAP has been accepted.
- One Focused Survey was initiated on one Partial Capitation plan based on their late MSA / IPA Contract submission. A SOD was issued to the plan and the CAP has been accepted.
- One Focused Survey was initiated on one Partial Capitation plan based on TAC complaints received for inappropriate SDC denial notices. A SOD was issued to the Plan and the CAP has been accepted.
- One TAC Investigation was initiated on one Partial Capitation plan TAC complaints received for inappropriate SDC reduction notices. A SOD was issued to the Plan and DOH is working to address the Plan's concerns.
- One Focused Survey was initiated on all Partial Capitation Plans based on an analysis of their 2023 Q1 PNDS Submissions. SODs were issued to 19 Plans and their CAPs have been received but are under department review.
- One TAC Investigation was initiated on one Partial Capitation plan TAC complaint received for failure to oversee their Fiscal Intermediaries, as well as failure to provide adequate care management. A SOD was issued to the Plan and DOH is awaiting receipt of a CAP.

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
- There are no significant issues or problems to report, however survey training continues for new/promoted team members. Additionally, two team members have transitioned to new roles out of the Surveillance Unit.

3. Issues and Problems

There were no issues or problems to report for the July 2023 through September 2023 quarter, nor for the October 2022 through September 2023 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 DOH began a procurement process in December 2019 which was subsequently amended in the Executive Budget in April 2022. The amended legislation directly provided the criteria a Fiscal Intermediary (FI) must meet to contract with the DOH to continue to provide fiscal intermediary administrative services for the Consumer Directed Personal Assistance Program (CDPAP). In June 2023 DOH made additional awards under this criterion and has begun the contracting process for all awardees. Once contracts are executed, managed care plans will then enter into separate administrative service agreements with these Department-contracted FIs.

5. Required Quarterly Reporting

Critical incidents: There were 3,440 critical incidents reported for the July 2023 through September 2023 quarter, an increase of 10% from the previous quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey.

Critical incidents by plan for this quarter are attached.

For the annual period October 2022 through September 2023 reporting of critical incidents increased by 34% 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 2023 through September 2023 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with Care Management, Dissatisfaction With Member Services and Plan Operations, Dissatisfaction With Transportation, Plan Staff Rude or Abusive, Dissatisfied with Choice of Providers in Network.

Period: 7/1/2023–9/30/2023 (Percentages rounded to nearest whole number)			
Number of Recipients: 324,826	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**12**	**11**	**92%**
# Same Day	**3,019**	**3,019**	**100%**
# Standard/Expedited	**8,497**	**6,290**	**74%**
Total for this period:	**11,528**	**9,320**	**81%**

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

Appeals	10/2022-12/2022	1/2023-3/2023	4/2023-6/2023	7/2023-9/2023	Average for Four Quarters
Average Enrollment	297,328	304,375	313,672	321,917	309,323
Total Appeals	10,284	10,461	12,228	10,762	10,934
Appeals per 1,000	36	34	39	33	36
# Decided in favor of Enrollee	1,081	1,224	1,331	1,220	1,214
# Decided against Enrollee	7,143	8,103	8,571	8,263	8,020
# Not decided fully in favor of Enrollee	845	871	921	915	888
# Withdrawn by Enrollee	236	263	300	329	282
# Still pending	979	1,195	1,105	1,099	1,095
Average number of days from receipt to decision	10	7	6	7	8

Complaints and Appeals per 1,000 Enrollees by Product Type July 2023- September 2023					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	270,541	6,941	26	8,183	30
Medicaid Advantage Plus (MAP) Total	40,321	3,262	81	2,459	61
PACE Total	9,327	1,325	142	84	9
Total for All Products:	**320,189**	**11,528**	**36**	**10,726**	**33**

Total complaints increased 3% from 11,197 the previous quarter to 11,528 during the July 2023 through September 2023 quarter.

Total appeals decreased 12% from 12,228 during the last quarter to 10,726 during the July 2023 through September 2023 quarter.

For the annual period October 2022 through September 2023, the number of complaints increased by 2%, and the number of appeals increased by 27%.

Technical Assistance Center (TAC) Activity

During the July 2023 through September 2023 quarter, TAC opened 765 cases and closed 749 cases. This is slightly higher than the 756 cases opened, and lower than the 778 cases closed from the previous quarter. Upon examination, this quarter's change in cases is equally spread across the different types of case dispositions, outlined in the table below. There was not one specific disposition that caused the change.

Most of TAC's cases for this quarter were for general inquiries and questions. Complaints regarding home health care services continue to be the highest complaint category.

Call Volume	**7/1/2023 – 9/30/2023**
Substantiated Complaints	78
Substantiated Complaints with Corrective Action Plan	1
Unsubstantiated Complaints	243
Resolved Without Investigation	10
Inquiries	417
Total Cases Closed	749

The five most common types of calls were related to:

Q4 2023	**7/1/2023 – 9/30/2023**
General	29%
Aide Service	16%
Enrollment	11%
Billing	9%
Coverage Concerns	7%

77% of Q4 TAC cases were closed in the same month they were opened. This is a 2% decrease from last quarter's percentage of 79%.

During the annual period from October 2022 through September 2023, TAC opened 2,711 cases and closed 2,687 cases. The majority of the closed cases are for general questions and inquiries. About 74% of TAC's complaint investigations were found to be unsubstantiated. TAC issued 18 CAPs in 2023.

Most of TAC's cases for this year were for general inquiries and questions. Complaints regarding home health care services continue to be the highest complaint category.

Call Volume	10/1/2022-9/30/2023
Substantiated Complaints	298
Unsubstantiated Complaints	910
Corrective Action Plans	18
Resolved Without Investigation	45
Inquiries	1,416
Total	2,687

The five most common types of calls were related to:

Types of Calls	10/1/2022-9/30/2023
General	31%
Aide Service	16%
Enrollment	11%
Billing	8%
Grievance	7%

For the entire year, 74% of cases were closed in the same month they were opened. This efficiency increased over the course of the year, from 75% in October 2022 to 79% in September 2023.

Evaluations for enrollment: New York Independent Assessor Program (NYIAP) 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 2023 through September 2023 quarter, 8,217 people were evaluated, deemed eligible and enrolled into plans, an increase of 11% from the previous quarter.

This brings the total for the annual period October 2022 through September 2023 to 30,380. NYS continues to see quarter to quarter variability in the number of individuals requesting assessments and the number who are deemed eligible.

Rebalancing Efforts	7/2023-9/2023
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	313
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,674

As of September 30, 2023, there were 3,479 current plan enrollees who were in NH as permanent placements, a slight 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 HCBS needs, including medically fragile children, children with a BH needs, 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,** for an effective date of April 1, 2022. Additionally, a new Children's Waiver Amendment was approved by CMS on November 1, 2023, to amend a number of activities detailed in the sections below.

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

- Managed care authority for HCBS provided to medically fragile children and/or with developmental disabilities, developmental disability in foster care, and children with a serious emotional disturbance.
- Authority to include current FFS HCBS authorized under the State's newly consolidated 1915c Children's Waiver in MMC benefit packages.
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915c Children's Waiver.
- Authority to waive deeming of income and resources, if applicable, for all medically needy "Family of One" children (Fo1 children) who will lose their Medicaid eligibility as a result of them no longer receiving at least one 1915c service due to case management now being covered outside of the 1915c Children's Waiver, including non-Supplemental Security Income Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs.
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115.
- Authority 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 NYS 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 MCOs, HCBS providers, and care managers to improve communication and care coordination.
- Coordinating stakeholder meetings to obtain feedback from MCOs, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation.
- Evaluating accuracy of MCOs and FFS 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.
- Assisting with a strategic plan for the unwind of the COVID-19 PHE.
- Conducting annual case reviews of both Health Homes, C-YES, and HCBS providers.
- 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, allow for provider reporting and assess metrics regarding highly utilized HCBS, underutilized HCBS, and overutilized providers.
    - Modified state-wide capacity tracking system, which is based on providers self-reporting, to enhance the understanding of the HCBS waitlist and who is being served by HCBS, a referral and authorization portal is being built which will give more accurate information that is not dependent upon self-reports of providers.
- Engaging with providers, consumers, and NYS agency partners to determine how best to use the eFMAP authorized by ARPA to improve access to children's services and reduce administrative burden on providers – including increasing rates for HCBS and directing funding to service providers for workforce development and IT infrastructure.
- Collecting stakeholder feedback (from consumers, HCBS providers, Health Homes, MCOs, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between MCOs, Health Homes, and HCBS providers.
- Organizing and conducting workgroups of Health Homes, MCOs, and HCBS Providers to ensure feedback is addressed relating to the referral process.
- Engaging with Health Homes, MCOs, 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.
- Submitted the 1915c Children's Waiver Extension to CMS.
- Submitted the 1915c Children's Waiver Renewal to CMS.
- Submitted a State Transition Plan to CMS to detail how agencies providing services under the 1915c Waiver comply with the HCBS Final Rule.
- Submitted a preprint to CMS for the disbursement of ARPA funding to support and enhance HCBS workforce and infrastructure.
- Working with MCOs and providers to disseminate ARPA funding through the directed payment process.

- Scheduling and facilitating regional meetings with HCBS providers, Health Homes, care management agencies, Medicaid MCOs to resume in-person collaboration and dialogue.
- Updating the IRAMS and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- 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.
- Drafting documentation guidance to ensure compliance with documentation of services being delivered to Children's Waiver participants, progress toward goals, significant life events, and medical necessity requirements for each HCBS.
- Submitted additional preprint to CMS for the disbursement of ARPA funding to support children in need of receiving Environmental Modifications (EMOD), Vehicle Modifications (VMod) & Adaptive and Assistive Technology (Ats).
- Engaging with Health Homes to support the transition of EMod/VMod/Ats from NYS DOH to Financial Management Services (FMS).

Additionally, the NYS DOH has been implementing and altering activities and services, including, but not limited to, the following:

- Submitting Disaster SPA 21-0054, which is pending approval for the assessment fee retroactive to April 1, 2021.
- Submitted a SPA 22-0088, which would continue the assessment fee effective October 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 also 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.
- Adding a 5.4% COLA increase for providers starting April 1,2022.
- NYS support of the continued 25% enhanced HCBS rates on October 1, 2022.
- Adding a 4% COLA increase for providers, starting November 1, 2023, based upon approval for Children's Waiver amendment.
- Developed Electronic Children's Services Staff Compliance Tracker.

- Updated Children's Care Management Authorization and Referral Forms ensuring it's inclusive of all requirements per stakeholder feedback.
- Updated IRAMS User Guide used by HH, CMA, HCBS Providers, and C-YES to report critical incidents and complaints/grievances as appropriate for the various populations served to ensure the health, safety, and well-being of members.
- Developing Electronic Children's Referral System which would streamline, standardize, and ensure timely completion of referral per policy.
- Updating Children's Plan of Care Policy Workflow documentation to align and streamline policies and ensure language is comprehensive of the newly developed timeframes and follow Person-Centered Service Planning Guidelines.
- Drafting an Authorization Workflow Policy that will be circulated to stakeholders for feedback.
- Drafting a Referral Workflow Policy that will be circulated to stakeholders.

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

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
10/1/2022	15,207	7,841	6,618	899
11/1/2022	15,546	8,036	6,702	904
12/1/2022	15,743	7,769	6,753	852
Quarter 1 Average	15,499	7,882	6,691	885
1/1/2023	15,947	7,838	6,816	887
2/1/2023	15,706	7,460	6,833	899
3/1/2023	15,428	7,504	6,922	916
Quarter 2 Average	15,694	7,601	6,857	901
4/1/2023	15,153	7,282	6,882	879
5/1/2023	15,018	7,404	6,902	896
6/1/2023	14,524	6,981	6,949	853
Quarter 3 Average	14,898	7,222	6,911	876
7/1/2023	13,618	6,070	6,207	640
8/1/2023	13,310	4,805	5,995	430
9/1/2023	12,953	2,760	5,706	180

Quarter 4 Average	13,294	4,545	5,969	417
Annual Average	**15,189**	**7,419**	**6,758**	**863**

**There is an expected 3-month lag for claims data that may impact the enrolled children with an HCBS claim data.*

This table includes annual data from 10/1/2022 to 9/30/2023 of FY2023.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 evaluation design to CMS for review and approval. CMS returned the evaluation design with comments on April 18, 2023. DOH submitted a revised evaluation design to CMS on June 20, 2023, pending their review and approval. The evaluation design for the Managed Care Risk Mitigation COVID-19 PHE amendment was approved by CMS on January 10, 2023. The evaluation design for the Reasonable Opportunity Period (ROP) Extension COVID-19 PHE amendment is pending CMS review and approval.

VII. Consumer Issues

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

MCOs, including MMC plans, HARPs, and HIV SNPs, are required to report quarterly to the DOH 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 compared to the last four quarters.

MCO Product Line	Total Complaints	
	FFY 23 Q4 7/1/2023–9/30/2023	**FFY 23 10/1/2022–9/30/2023**
MMC	5,434	25,728
HARP	586	2,785
HIV SNP	78	328
Total MCO Complaints	**6,098**	**28,841**

As described in the table, MCOs reported 6,098 total enrollee complaints for the current quarter. This represents a 1.9% decrease from the prior quarter's total of 6,098 enrollee complaints.

MCOs reported 5,434 MMC complaints this quarter, which is a 0.6% increase from the 5,403 of the previous quarter. The number of HARP complaints decreased 19.4%, from 727 in the prior quarter to 586 this quarter. There were 78 HIV SNP complaints this quarter, which is a decrease of 9.3% when compared to the 86 from the previous quarter.

The following table outlines the top five most frequent categories of complaints reported for MMCs, HARPs, and HIV SNPs, combined, for the most recent quarter and compared to the last four quarters.

Description of Complaint	Percentage of Complaints	
	FFY 23 Q4 7/1/2023–9/30/2023	FFY 23 10/1/2022–9/30/2023
Balance Billing	15%	13%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	16%
Difficulty with Obtaining: Dental/Orthodontia	12%	11%
Reimbursement/Billing	7%	8%
Dissatisfaction with Quality of Care	6%	6%

The following table outlines the top five most frequent categories of complaints reported for HARPs for the most recent quarter and compared to the last four quarters.

Description of Complaint	Percentage of Complaints	
	FFY 23 Q4 7/1/2023–9/30/2023	FFY 23 10/1/2022–9/30/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	25%	23%
Dissatisfaction with Quality of Care	12%	10%
Difficulty with Obtaining: Dental/Orthodontia	7%	6%
Difficulty with Obtaining: Personal Care	6%	4%
Balance Billing	5%	5%

The following table outlines the top five most frequent categories of complaints reported for HIV SNPs for the most recent quarter and compared to the last four quarters:

Description of Complaint	Percentage of Complaints	
	FFY 23 Q4 7/1/2023–9/30/2023	FFY 23 10/1/2022–9/30/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	24%	24%
Problems with Advertising/Consumer Education/ Outreach/Enrollment	19%	12%
Difficulty with Obtaining: Dental/Orthodontia	9%	13%
Dissatisfaction with Quality of Care	9%	11%
Difficulty with Obtaining: Personal Care	6%	7%

B. Monitoring of Plan Reported Complaints

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

The OE ratios are calculated by DOH 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, DOH requests that MCOs review and analyze applicable categories in which the reported number of complaints was more than twice the expected amount. Where a persistent trend or an operational concern contributing to complaints is confirmed, the MCO is required to develop a CAP.

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

Amida Care FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**OE Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	11.8	The trend identified from the complaints received was that enrollees were dissatisfied with the medication, treatment, and/or overall care received at various hospitals and physician's offices. The issues identified were that care was not coordinated with enrollees' primary care physician (PCP) while receiving care in the hospital, and that enrollees were not fully informed about their procedure(s).	The MCO will address coordinated care issues by developing internal teams to strengthen operational processes related and by educating and following up with providers who do not follow the proper procedures to improve their process and prevent further issues. The MCO will address lack of information given to enrollees about their procedures by following up and educating providers on the need to discuss possible outcomes, successes, and limitations of surgical procedures and the need to document these discussions.
Dissatisfaction with Provider Services	11.1	The trend identified from the complaints received	The MCO will address poor customer service by coaching

(Non-Medical) or MCO Services		was that the MCO's call center representatives, provider offices, and vendors were not providing the best customer service to enrollees. The issues identified were that representatives were rude, did not provide adequate information, delayed sending earned incentives, and misgendered the enrollees.	representatives on appropriate call etiquette. The MCO addressed delays in their vendor's incentive program by streamlining the attestation process and following up with providers who did not submit their attestations timely. The MCO addressed enrollees being misgendered by their vendor by ensuring that the representative was coached by the vendor and that the vendor circulated sensitivity training documents to all their representatives. The MCO addressed overall customer service issues by developing a new call monitoring process with additional quality assurance measures added daily and monthly for ongoing coaching for their representatives. The DOH will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Dental/ Orthodontia	4.9	The trends identified from the complaints received were that enrollees were experiencing difficulty accessing services and covered benefits such as dentures, out-of-network providers would not provide services due to the fee schedule, providers requested payments for services from enrollees, and providers charged cancellation fees. The issues identified were that enrollees were not able to locate in-network providers or identify their covered benefits, and that providers were not aware of the covered services in the benefit.	The MCO will address enrollee difficulty finding in-network providers by developing and mailing educational materials to enrollees outlining the covered services and by working with their dental vendor to host events which will educate enrollees on the dental benefit. The MCO will address provider lack of information by working with their dental vendor, which was recently acquired and will have access to more resources, to conduct provider trainings and customer service reviews.

Capital District Physicians Health Plan FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	3.1	There were no trends identified by the MCO. The issue identified was that enrollees were dissatisfied with the continuity and quality of care received.	The MCO will address issues with quality of care by continuing to review such complaints for any trends or multiple complaints regarding the same provider, and by providing corrective action when appropriate.
Denial of Clinical Treatment	2.6	The trends identified from the complaints received were that enrollees were denied for medications that were not covered by the formulary, and that enrollees were denied for speech generating devices manufactured by an out-of-network provider. No issues were identified by the MCO.	The MCO will address denials of clinical treatments by closely monitoring appeals for trends and identifying CAPs when appropriate.
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	14.5	There were no trends identified by the MCO. The issues identified were that complaints were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected	The MCO will address miscategorized complaints by having two reviewers to ensure each complaint is categorized correctly before submission.
Reimbursement/Billing	2.3	The trend identified from the complaints received was that enrollees were being billed for services. The issues identified were that enrollees were unknowingly being seen by out-of-network providers and that enrollees did not know which coverage was primary.	The MCO will address enrollee lack of knowledge regarding in-network providers and primary coverage by educating its enrollees.

Healthfirst FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: Specialist	2.4	The trends identified from the complaints received were that enrollees were dissatisfied with the lack of specialists accepting new patients, the length of time until an appointment is available, the commute time to specialists with available appointments, and providers rescheduling their appointments, sometimes with short notice. The issue identified was that there were areas with insufficient dental appointments available.	The MCO will address the lack of specialist appointment availability by conducting monthly provider directory audits with its dental vendor and by ensuring its dental vendor completes quarterly outreach campaigns to verify accuracy of its dental directory. The MCO will address enrollee difficulty with locating an in-network specialist by having its call center representatives call provider offices to obtain appointments for enrollees and by providing information on non-emergency transportation options to enrollees. The MCO will escalate and address all issues in which a provider is found to be out of compliance with appointment availability standards while assisting enrollees in locating a provider.
Long Wait Time	3.3	The trends identified from the complaints received were that enrollees were dissatisfied with the length of time spent waiting in the office upon arriving to their appointments, the wait times associated with walk-in appointments, and the length of time for checking in to an appointment. There were no issues identified by the MCO.	The MCO will address long wait times for enrollees by working with its vendor to monitor and find opportunities for more appointments, conducting remediation in cases in which the providers fail to meet their service level agreements, educating its providers on appropriate wait times, and conducting more frequent access and availability surveys with an emphasis on improving the enrollee experience.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	3.0	The trend identified from the complaints received was that enrollees were experiencing issues related to durable medical	The MCO will continue to address DME concerns by updating its talking points to provide clarification for enrollees on how the pharmacy carve-out

		equipment (DME), including delivery issues and lack of prescription. The issue identified was that DME vendors were delayed in their deliveries to enrollees.	would impact their DME, routing authorizations away from vendors with extended delivery times, increasing access to preferred brands after changes to the formulary, and sending out an email to service agents to help them assist enrollees.
Difficulty with Obtaining: Specialist and Hospitals	2.1	The trends identified from the complaints received were that enrollees were being denied for services, experiencing delays with responses from specialist office staff, experiencing difficulty with obtaining prior authorizations and prescriptions, experiencing issues with having appointments with in-network providers that are not canceled or rescheduled, and not receiving requested medical records. The issues identified were that enrollees were having difficulty reaching specialist and hospital offices by phone, and some providers were not submitting prescriptions to pharmacies and medical records to enrollees or providers timely and were not following enrollee preferences for their treatment plans.	The MCO will address enrollee difficulty locating in-network providers, scheduling appointments, and understanding their benefit package by providing talking points and job aids to their customer service representatives. The MCO will address individual providers with multiple complaints or appeals by monitoring and administering CAPs or enforcing contractual obligations when needed. The MCO will address providers not meeting enrollee satisfaction standards by providing feedback and coaching to providers.
Difficulty with Obtaining: Emergency Services	3.8	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 there was no claim on file for out-of-network emergency room visits,	The MCO will address out-of-network emergency rooms billing enrollees by negotiating reimbursement rates with such providers. The MCO will address enrollees not presenting their insurance cards by enhancing their call center representatives' scripts to include awareness regarding out-of-network billing

		emergency rooms were balance billing enrollees, and enrollees were not presenting their insurance cards and were receiving bills for emergency room visits.	issues, including a reminder to present their insurance cards at all visits. The DOH will continue to monitor progress in the next reporting period.
Pharmacy\Formulary	2.4	The trend identified from the complaints received was that enrollees were being denied their prescriptions by pharmacies. The issues identified were that requested drugs were not covered by the formulary, enrollees were not getting prior authorization when needed, and enrollees were requesting to refill their drugs too soon when there were plan limits or no more overrides.	The MCO, in accordance with the pharmacy benefit carve-out, will no longer be providing pharmacy benefits to its enrollees, and will no longer have oversight over this benefit. The MCO will coordinate with NYRx, the pharmacy benefit manager, to assist with its enrollees' issues as needed. The MCO will continue to provide care coordination for its enrollees.
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 enrollees were being referred to out-of-network specialists by their in-network providers, enrollees were not presenting their insurance cards at their visits, and enrollees were being billed for services when private pay agreements had been signed.	The MCO is addressing enrollees receiving bills for services by proactively outreaching and educating its providers on policies and procedures such as not balance billing Medicaid enrollees and informing enrollees of private pay agreements before providing the service, and by intervening when out-of-network providers balance bill their enrollees.
Recipient Restriction Program Plan Initiated Disenrollment	4.2	The trends identified from the complaints received were that enrollees were dissatisfied with being restricted to a pharmacy and with the processing time for a pharmacy	The MCO, in accordance with the pharmacy benefit carve-out, will no longer be providing pharmacy benefits to its enrollees, and will no longer have oversight over this benefit. The MCO will address enrollee

		restriction change request. The issue identified was that enrollees were unfamiliar with the process and the mandated recipient restriction program directive from the Office of the Medicaid Inspector General (OMIG).	misinformation by enhancing its verbiage in its communications to enrollees.
Difficulty with Obtaining: Private Duty Nursing	4.4	The trend identified from the complaints received was that enrollees were dissatisfied with their private duty nursing (PDN) agencies and aides. The issues identified were that some personal care aides were absent or tardy, unprofessional, had poor communication in informing enrollees of aide changes, and did not provide satisfactory quality of service.	The MCO will address enrollee dissatisfaction by using a new system to track scheduling issues and missed visits in real time, by creating single case agreements (SCAs) with out-of-network providers when needed, and by working with providers to resolve staffing shortages and performance issues.
Difficulty with Obtaining: Personal Care	4.0	The trend identified from the complaints received was that enrollees were dissatisfied with their personal care agencies and aides. The issues identified were that some personal care aides were absent or tardy, unprofessional, inexperienced, and did not provide satisfactory quality of service.	The MCO will address enrollee dissatisfaction by using a new system to track scheduling issues and missed visits in real time, by creating SCAs with out-of-network providers when needed, and by working with providers to resolve staffing shortages and performance issues.
Difficulty with Obtaining: CDPAS	4.0	The trend identified from the complaints received was that enrollees were having processing problems with CDPAS, including delays in authorization for services and delays in aides receiving payment for services. The issues identified were that fiscal	The MCO will address payment delays by working with providers to mitigate any issues. The MCO will address authorization delays by conducting monthly calls with providers to review forms and common issues, by increasing outreach and support to enrollees to review the form requirements, and by expanding the use of DocuSign electronic

		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.	signing instead of only using mailed paper forms. The DOH will continue to monitor progress in the next reporting period.

Health Insurance Plan of Greater New York FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	6.8	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 address enrollees being uninformed about their dental coverage by following up with enrollees and providers and educating them on the covered services as well as where to find this information in the Member Handbook.
Communications/ Physical Barrier	7.7	There were no trends identified by the MCO. The issue identified was that complaints were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected	The MCO will address miscategorized complaints by retraining their staff on proper categorization.
Reimbursement/Billing	3.9	The trend identified from the complaints received was that enrollees were dissatisfied that their claims were unpaid. The issue identified from the complaints received was that enrollees were questioning claims being denied for services rendered by out-of-network providers, or due to no authorization or referral on file.	The MCO will address claims from out-of-network providers by educating its providers to only refer to in-network providers and to confirm authorization or a referral on file prior to rendering services, and by educating its enrollees to only obtain services from in-network providers.

Independent Health Association FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.9	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 address enrollee complaints by continuing to conduct provider outreach to identify issues. The MCO will address identified provider issues by instituting provider CAPs as needed. The DOH will continue to monitor progress in the next reporting period.

MetroPlus Health Plan FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	3.0	The trend identified from the complaints received was that enrollees were dissatisfied with having to pay a copay for frames that were not included in the standard vision package. The issue identified was that enrollees and providers were unaware of what was covered under the insurance benefit.	The MCO addressed enrollees and providers being unaware of their coverage by advising enrollees that they can locate their benefit information on the MCO's website, and by advising providers on the importance of differentiating between covered benefits and out-of-pocket costs to enrollees, to help ensure that enrollees are aware of any financial responsibility if they select non-covered frames.

Molina Healthcare FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	5.3	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	The MCO will address enrollees being unable to locate providers by providing a tutorial for navigating the member web portal during new enrollee orientation. The MCO will address providers not meeting access and availability standards by continuing to reach out to PCP offices to ensure adequate

		meeting access and availability standards.	appointment availability for enrollees.
Difficulty with Obtaining: Specialist and Hospitals	5.8	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 will address enrollee difficulty locating specialist providers by providing a tutorial for navigating the member web portal during new enrollee orientation, and by instructing its member services department to assist enrollees with using the provider directory.
Pharmacy/Formulary	3.9	The trends identified from the complaints received were delays in prior authorization, reported eligibility issues, and enrollees being unable to fill prescriptions. There were no issues identified.	The MCO will address issues with providers submitting requests by continuing to educate its call center representatives on the necessary information required for prior authorization requests.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	9.6	The trend identified from the complaints received was that there was enrollee confusion regarding the use of the MCO's website and its provider directory. There were no issues identified.	The MCO addressed enrollee confusion with its website and directory by updating their website to include an online YouTube tutorial that introduces enrollees to the MCO's mobile app and demonstrates how to register for and access the enrollee portal.
All Other	15.1	The trend identified from the complaints received 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.	The MCO will reduce the likelihood of incorrectly submitted requests by educating providers on the authorization process on the MCO's provider portal. The MCO will attempt to better understand and prevent any trending issues by instructing its staff to include more details in each complaint when this category is selected. The DOH will continue to monitor progress in the next reporting period.

Balance Billing	10.7	The trend identified from the complaints received was that providers were billing enrollees for services received. The issues identified were that enrollees failed to present insurance ID cards and providers were unaware of the process for identifying enrollee insurance.	The MCO will address enrollees being billed by continuing to educate providers on ensuring that they have the correct enrollee information and the importance of not billing the enrollee. The DOH will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Home Health Care	10.0	The trend identified from the complaints received was that enrollees in need of home health care did not know the process for requesting it and were unaware that they could utilize care manager services. The issues identified were that enrollees in need of home health care did not have assessments conducted and did not submit the necessary documentation.	The MCO addressed enrollees being unaware of the process by having their care manager reach out to them to reeducate them on the necessary steps to obtain home health care.

MVP Health Plan FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	5.1	The trends identified from the complaints received were inappropriate billing, inappropriate treatment provided, lack of appointment availability, lack of in-network providers within a reasonable distance from the enrollee's home, unprofessional attitude from office staff, and enrollee dissatisfaction with plan benefits. There were no issues identified.	The MCO addressed enrollee dissatisfaction by having its vendor identify any providers or provider offices in need of corrective action, then providing those offices with reeducation on billing appropriately, professional conduct, and the importance of reviewing treatment plans with enrollees in detail for their understanding. The DOH will continue to monitor progress in the next reporting period.

United Healthcare FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.9	The trend identified from the complaints received was that enrollees were dissatisfied with their care. The issues identified were that providers failed to properly diagnose enrollees, explain medical results and treatment plans, and efficiently document medical records.	The MCO will address enrollees' quality of care issues and provider communication concerns by determining which providers need corrective action and sending out CAP letters; providing verbal or written counseling; conducting focused medical care reviews; and restricting, suspending, or terminating network participation, if necessary.
Denial of Clinical Treatment	12.4	The trend identified from the complaints received was that enrollees were receiving denials for services. There were no issues identified.	The MCO will address enrollee denials by continuing to monitor denials and implement remediation when necessary. The DOH will continue to monitor progress in the next reporting period.
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 counties in New York's rural areas did not have in-network dental specialists.	The MCO will address network adequacy issues by working to find an in-network provider when possible, and by working with out-of-network providers to create single case agreements.
Communications/ Physical Barrier	5.5	The trend identified from the complaints received was rude or unprofessional behavior from providers and MCO staff members. There were no issues identified.	The MCO will address rude or unprofessional behavior by providing individualized coaching to their staff members. The MCO has identified a gap in grievance category classification for rude providers and is working to implement measures to prevent miscategorization of complaints.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	3.5	The trends identified from the complaints received included enrollees having trouble with changing their PCP, updating their	The MCO will assist enrollees by continuing to make welcome calls to the enrollees, at which time they will confirm their PCP choice and verify their address

		address, and not receiving their ID card. There were no issues identified.	for accuracy to ensure the ID card is sent to the right address. The MCO will then work with the enrollee and NYSoH if necessary if there are changes that need to be made to the enrollee's information.

VNS Choice FFY 23 Q2–FFY 23 Q3 (1/1/2023–6/30/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	19.7	The trends identified from the complaints received were that enrollees were receiving denials for non-covered dental services, enrollees were dissatisfied with the quality of services provided, treatment provided was not what the enrollees sought treatment for, and services were unable to be performed due to a lack of prior authorization. The issue identified was that enrollees were unaware of what services were covered under their dental benefit.	The MCO will reduce enrollee misinformation about their benefit by continuing to provide educational materials to enrollees, including welcome kit inserts that detail the benefit and scope of coverage.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	207.0	The trend identified from the complaints received was that enrollees were dissatisfied with the amount of time it took to receive their VISA reward cards. The issue identified was that the original VISA reward card selected was not in compliance with "Final Rule: Medicare and State Health Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements",	The MCO did not implement a CAP as the complaints were in relation to a delay in the reward cards being sent out, which will no longer occur now that they have been reviewed for compliance. The MCO notes that there have not been any complaints about the reward cards after they were received.

		so the MCO had to review and select a new card to send to enrollees.	

C. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, DOH monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 6,098 total reported complaints/action appeals, MCOs reported 532 complaints and action appeals from their SSI recipients. This compares to 513 SSI complaints/action appeals from the previous quarter, representing a 3.7% increase.

The following table outlines the total number of complaints/action appeals MCOs reported for SSI recipients by category for the most recent quarter and compared to the last four quarters.

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 23 Q4 7/1/2023–9/30/2023	FFY 23 10/1/2022–9/30/2023
Appointment Availability: PCP	1	5
Appointment Availability: Specialist	1	9
Appointment Availability: BH HCBS	0	0
Long Wait Time	4	8
Dissatisfaction with Quality of Care	36	168
Denial of Clinical Treatment	5	61
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	173	565
Dissatisfaction with BH Provider Services	0	3
Dissatisfaction with Health Home Care Management	2	15
Difficulty with Obtaining: Specialist and Hospitals	32	98
Difficulty with Obtaining: Eye Care	5	15
Difficulty with Obtaining: Dental/Orthodontia*	41	148
Difficulty with Obtaining: Emergency Services	1	5
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	1	5
Difficulty with Obtaining: RHCF Services	0	5
Difficulty with Obtaining: Adult Day Care	0	1
Difficulty with Obtaining: Private Duty Nursing	16	31
Difficulty with Obtaining: Home Health Care	9	20
Difficulty with Obtaining: Personal Care	61	132
Difficulty with Obtaining: PERS	1	2
Difficulty with Obtaining: CDPAS	17	48
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	6	142

Access to Non-Covered Services	8	27
Access for Family Planning Services	0	1
Communications/ Physical Barrier	4	11
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	2	10
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	42	192
Balance Billing	30	96
Transportation	0	2
All Other	34	93
Total	**532**	**1,918**

The following table outlines the top five most frequent categories of SSI recipient complaints/action appeals MCOs reported for the most recent quarter and compared to the last four quarters:

Description of Complaint	**Percentage of Total Complaints/Appeals Reported for SSI Recipients**	
	FFY 23 Q4 7/1/2023–9/30/2023	**FFY 23 10/1/2022–9/30/2023**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	33%	29%
Difficulty with Obtaining: Personal Care	11%	7%
Reimbursement/Billing	8%	10%
Difficulty with Obtaining: Dental/Orthodontia	8%	8%
Dissatisfaction with Quality of Care	7%	9%

The DOH 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, 2023, through September 30, 2023, MCOs reported LTSS enrollment of 57,861 enrollees. This compares to 56,020 LTSS enrollees from the previous quarter, representing a 3.3% increase. The following table outlines the number of LTSS enrollees by MCO for each of the last four quarters:

Plan	**Number of LTSS Enrollees**			
	FFY 23 Q4 7/1/2023–9/30/2023	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**	**FFY 23 Q1 10/1/2022–12/31/2022**
Amida Care	1,259	1,271	1,318	1,252
Capital District Physicians Health Plan	764	774	771	755
Excellus Health Plan	1,640	1,640	1,640	1,547
Fidelis Care	20,807	20,375	19,562	19,170
Healthfirst	15,096	14,448	14,033	13,986
Highmark	286	255	242	219
HealthPlus	3,920	3,643	3,292	2,941
HIP of Greater New York	502	493	642	630

Independent Health Association	748	709	670	625
MetroPlus Health Plan	3,475	3,280	2,805	3,021
Molina Healthcare	2,923	2,851	2,936	2,742
MVP Health Plan	2,541	2,435	2,347	2,284
United Healthcare	3,435	3,384	3,266	3,164
VNS Choice	465	462	407	415
Total	**57,861**	**56,020**	**53,931**	**52,751**

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 23 Q4 7/1/2023–9/30/2023	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**	**FFY 23 Q1 10/1/2022–12/31/2022**
Difficulty with Obtaining: AIDS Adult Day Health Care	0	1	0	0
Difficulty with Obtaining: Adult Day Care	1	3	3	4
Difficulty with Obtaining: CDPAS	55	59	69	93
Difficulty with Obtaining: Home Health Care	63	58	50	29
Difficulty with Obtaining: RHCF Services	4	7	1	1
Difficulty with Obtaining: Personal Care	196	157	162	164
Difficulty with Obtaining: PERS	2	3	3	3
Difficulty with Obtaining: Private Duty Nursing	27	16	21	24
Total	**348**	**304**	**309**	**318**

D. Critical Incidents

The DOH requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 126 critical incidents reported for the July 1, 2023, through September 30, 2023, period most of which have a resolved status. Many of the incidents stemmed from falls. The DOH 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 quarters, the net change over the last two quarters, and for the total for the last four quarters:

Plan	Critical Incidents			
	FFY 23 Q4 7/1/2023–9/30/2023	FFY 23 Q3 4/1/2023–6/30/2023	Net Change	FFY 23 10/1/2022–9/30/2023
Medicaid Managed Care Plans				
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	11	3	+8	40
Fidelis Care	3	2	+1	12
Healthfirst	65	72	-7	246
HIP of Greater New York	0	0	0	0
Highmark	0	0	0	1
HealthPlus	0	1	-1	1
Independent Health Association	0	0	0	0
MetroPlus Health Plan	0	0	0	0
Molina Healthcare	1	3	-2	4
MVP Health Plan	1	0	+1	3
United Healthcare	0	0	0	0
Total	**81**	**81**	**0**	**307**
Health and Recovery Plans				
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	2	0	+2	2
Fidelis Care	0	0	0	0
Healthfirst	38	40	-2	161
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	0	0	0
MVP Health Plan	0	0	0	0
United Healthcare	0	0	0	0
VNS Choice	0	0	0	0
Total	**41**	**40**	**+1**	**164**
HIV Special Needs Plans				
Amida Care	0	0	0	0
MetroPlus Health Plan	0	0	0	0
VNS Choice	4	5	-1	24
Total	**4**	**5**	**-1**	**24**
Grand Total	**126**	**126**	**0**	**495**

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 quarters, the net change over the last two quarters, and the total for the last four quarters:

Category of Incident	Critical Incidents			
	FFY 23 Q4 7/1/2023–9/30/2023	FFY 23 Q3 4/1/2023–6/30/2023	Net Change	FFY 23 10/1/2022–9/30/2023
Medicaid Managed Care Plans				
Any Other Incidents as Determined by the Plan	2	5	-3	16
Crimes Committed Against Enrollee	3	0	+3	7
Crimes Committed by Enrollee	0	2	-2	2
Instances of Abuse of Enrollees	5	0	+5	12
Instances of Exploitation of Enrollees	0	0	0	2
Instances of Neglect of Enrollees	4	3	+1	17
Medication Errors that Resulted in Injury	0	0	0	0
Other Incident Resulting in Hospitalization	13	10	+3	44
Other Incident Resulting in Medical Treatment Other Than Hospitalization	53	60	-7	203
Use of Restraints	1	0	+1	1
Wrongful Death	0	1	-1	3
Total	**81**	**81**	**0**	**307**
Health and Recovery Plans				
Any Other Incidents as Determined by the Plan	1	1	0	2
Crimes Committed Against Enrollee	2	1	+1	3
Crimes Committed by Enrollee	4	2	+2	6
Instances of Abuse of Enrollees	0	1	-1	2
Instances of Exploitation of Enrollees	0	0	0	0
Instances of Neglect of Enrollees	0	0	0	0
Medication Errors that Resulted in Injury	0	0	0	0
Other Incident Resulting in Hospitalization	2	6	-4	21
Other Incident Resulting in Medical Treatment Other Than Hospitalization	32	28	+4	128
Use of Restraints	0	1	-1	2
Wrongful Death	0	0	0	0
Total	**41**	**40**	**+1**	**164**
HIV Special Needs Plans				
Any Other Incidents as Determined by the Plan	0	0	0	0
Crimes Committed Against Enrollee	0	0	0	0
Crimes Committed by Enrollee	0	0	0	0
Instances of Abuse of Enrollees	0	0	0	1

Instances of Exploitation of Enrollees	0	1	-1	1
Instances of Neglect of Enrollees	1	2	-1	13
Medication Errors that Resulted in Injury	0	0	0	0
Other Incident Resulting in Hospitalization	0	0	0	1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	3	2	+1	8
Use of Restraints	0	0	0	0
Wrongful Death	0	0	0	0
Total	**4**	**5**	**-1**	**24**
Grand Total	**126**	**126**	**0**	**495**

E. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the DOH directly received 106 enrollee complaints this quarter. This total is a 5% increase from the previous quarter, which reported 101 enrollee complaints.

Annually, the DOH directly received 363 MCO member complaints regarding MMCs, HARPs and HIV SNPs. The following table represents previously reported complaints filed directly with NYSDOH, including complaints from enrollees and their representatives.

MCO Enrollee Complaints Received Directly by the Department				
FFY 23 Q4 7/1/2023–9/30/2023	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**	**FFY 23 Q1 10/1/2022–12/31/2022**	**Total FFY 23 10/1/2022-9/30/2023**
106	**101**	**99**	**57**	**363**

The following table outlines the top five most frequent categories of enrollee complaints/action appeals received directly by the DOH involving MCOs for the most recent quarter and compared to the last four quarters:

Percentage of MCO Enrollee Complaints Received Directly by the Department				
Description of Complaint	**FFY 23 Q4 7/1/2023–9/30/2023**	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**	**FFY 23 Q1 10/1/2022–12/31/2022**
Reimbursement/Billing	15%	13%	16%	16%
Pharmacy/Formulary	14%	13%	10%	9%
Difficulty with Obtaining: Home Health Care	12%	9%	3%	8%
Difficulty with Obtaining: Dental/Orthodontia	12%	7%	4%	2%

Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	6%	0%	1%	0%

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

As per the NYSoH Marketplace: “Under the Families First Coronavirus Response Act’s continuous coverage requirement, New York State Medicaid, Child Health Plus (CHPlus) and Essential Plan (EP) members have not had to renew their health insurance since early 2020. The Consolidated Appropriations Act of 2023 requires states to begin the process of redetermining enrollees in April 2023. This process is also referred to as the ‘unwind.’ New York State began sending renewal notices in the early spring to enrollees in Medicaid, CHPlus, and EP with June 30, 2023, coverage end dates. This process will continue each month until every renewal cycle of enrollees, referred to as a cohort, has had their eligibility redetermined.”

The DOH will closely monitor the progress of the unwind as it proceeds.

F. Fair Hearings

There were 173 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of July 1, 2023, through September 30, 2023. The dispositions of these fair hearings for each of the last four quarters are as follows:

Fair Hearing Decisions (Includes MMC, HARP, and HIV SNP)				
Hearing Dispositions	**FFY 23 Q4 7/1/2023–9/30/2023**	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**	**FFY 23 Q1 10/1/2022–12/31/2022**
In favor of Appellant	58	78	79	68
In favor of Plan	101	171	168	121
No Issue	14	22	17	10
Total	**173**	**271**	**264**	**199**

For fair hearing dispositions occurring for each of the last four 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 23 Q4 7/1/2023–9/30/2023**	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**	**FFY 23 Q1 10/1/2022–12/31/2022**
0-29	0	1	8	4
30-59	13	57	44	45
60-89	37	67	43	39
90-119	39	54	52	50
=>120	84	92	117	61
Total	**173**	**271**	**264**	**199**

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

The MMCARP met on September 21, 2023. 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 no additional agenda items for this meeting. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for December 21, 2023.

Annual: The MMC Advisory Review Panel is required to meet quarterly. Meetings were held on December 15, 2022, March 16, 2023, June 15, 2023, and September 21, 2023.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

In December, DOH released the 2023 MLTC Quality Incentive Methodology document to MLTC plans.

During the January through March reporting period, preparations began for calculating MLTC quality, satisfaction, and compliance measures. Activities included: attributing MLTC members to accountable health plans based on annual assessment data per 2021 requirement changes, securing all data sources necessary for the calculation of the 2022 MLTC Quality Incentive, and updating the programs used to calculate measures to ensure agreement with the publicly released methodology. Additionally, DOHs EQRO, IPRO, sent the first mailing of the 2023 MLTC Satisfaction Survey to eligible members.

During the April through June reporting period, staff activities were focused on calculating MLTC quality, satisfaction, and compliance measures. Activities included: running measures, drafting the 2022 MLTC report, sharing preliminary measurement data with health plans for their review and feedback, and determining cut points for the tiers used in the MLTC quality incentive. Additionally, DOHs EQRO, IPRO, sent the second mailing of the 2023 MLTC Satisfaction Survey to eligible members.

The 2022 Quality Incentive awards were announced in August. The Quality Incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction,

and compliance. Since the MLTC is budget neutral, the bottom tier did not receive any contributed monies back, all the other tiers received back a portion or full amount of contributed monies plus additional award.

2022 Managed Long-Term Care Quality Incentive Results

Award Tier	Plan Name*	Quality Points (50-points possible)	Satisfaction Points (30-points possible)	Compliance Points (10-points possible)	Total Points	Base Points	Ranking Percent (up to 100%)
3	Complete Senior Care	33.9	5.0	7.5	46.4	62.9	73.9
3	ArchCare Senior Life	46.4	10.0	7.5	63.9	90.0	71.0
3	Eddy Senior Care	28.6	SS	7.5	36.1	52.9	68.2
3	Centers Plan for Healthy Living	32.1	20.0	7.5	59.6	90.0	66.3
3	Empire BCBS HealthPlus MLTC	33.9	15.0	10.0	58.9	90.0	65.5
3	MetroPlus MLTC	33.9	15.0	10.0	58.9	90.0	65.5
3	Catholic Health - LIFE	33.9	15.0	7.5	56.4	90.0	62.7
3	Hamaspik Choice	33.9	15.0	7.5	56.4	90.0	62.7
3	Senior Whole Health Partial	33.9	15.0	7.5	56.4	90.0	62.7
3	Hamaspik MAP	23.2	SS	5.0	28.2	45.7	61.7
3	Integra MLTC	25.0	20.0	10.0	55.0	90.0	61.1
2	VillageCareMAX	32.1	15.0	7.5	54.6	90.0	60.7
2	VillageCareMAX Total Advantage	30.4	15.0	7.5	52.9	90.0	58.7
2	RiverSpring MAP	16.1	SS	10.0	26.1	45.7	57.0
2	VNS Health Total	26.8	15.0	7.5	49.3	90.0	54.8
2	Elderplan	17.9	20.0	10.0	47.9	90.0	53.2
2	Prime Health Choice	25.0	15.0	7.5	47.5	90.0	52.8
2	AgeWell New York	14.3	25.0	7.5	46.8	90.0	52.0
1	Centers Plan MAP	17.9	SS	7.5	25.4	52.9	48.0
1	RiverSpring at Home	7.1	25.0	10.0	42.1	90.0	46.8

Award Tier	Plan Name*	Quality Points (50-points possible)	Satisfaction Points (30-points possible)	Compliance Points (10-points possible)	Total Points	Base Points	Ranking Percent (up to 100%)
1	Aetna Better Health	10.7	20.0	10.0	40.7	90.0	45.2
1	CenterLight PACE	17.9	15.0	7.5	40.4	90.0	44.8
1	Montefiore MLTC	12.5	17.5	10.0	40.0	90.0	44.4
1	Senior Whole Health	12.5	SS	7.5	20.0	45.7	43.8
1	EverCare Choice	14.3	17.5	7.5	39.3	90.0	43.7
1	VNS Health MLTC	16.1	15.0	7.5	38.6	90.0	42.9
1	MHI Healthfirst Complete Care	12.5	17.5	7.5	37.5	90.0	41.7
1	ElderONE	19.6	10.0	7.5	37.1	90.0	41.3
1	Senior Health Partners	7.1	20.0	10.0	37.1	90.0	41.3
0	Elderwood Health Plan	0.0	25.0	10.0	35.0	90.0	38.9
0	PACE CNY	12.5	12.5	10.0	35.0	90.0	38.9
0	Elderplan dba Homefirst	7.1	17.5	10.0	34.6	90.0	38.5
0	Kalos Health	16.1	10.0	7.5	33.6	90.0	37.3
0	Fidelis Care	5.4	15.0	10.0	30.4	90.0	33.7
0	iCircle	3.6	17.5	7.5	28.6	90.0	31.7
0	Senior Network Health	0.0	17.5	10.0	27.5	90.0	30.6
0	ArchCare Community Life	7.1	12.5	7.5	27.1	90.0	30.2
0	Fidelis Care MAP	7.1	SS	7.5	14.6	52.9	27.7
0	Total Senior Care	7.1	SS	7.5	14.6	52.9	27.7
0	Empire BCBS HealthPlus MAP	3.6	SS	10.0	13.6	52.9	25.7
0	Extended MLTC	0.0	15.0	7.5	22.5	90.0	25.0
0	Fallon Health Weinberg	0.0	15.0	7.5	22.5	90.0	25.0
0	Nascentia Health Options	0.0	15.0	5.0	20.0	90.0	22.2

Award Tier	Plan Name*	Quality Points (50-points possible)	Satisfaction Points (30-points possible)	Compliance Points (10-points possible)	Total Points	Base Points	Ranking Percent (up to 100%)
0	AgeWell New York Advantage Plus	0.0	SS	10.0	10.0	45.7	21.9
0	Fallon Health Weinberg-PACE	3.6	SS	5.0	8.6	45.7	18.8

In September, Crude Percent Reports for the January through December 2022 reporting period were released to MLTC plans. These reports are plan-specific and reflect each plan's cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this twelve-month period. The Crude Percent Report provides a breakout by percentage (unless a metric is reported as an average) of each response level for most components of the Community Assessment, Functional Supplement, and MH Supplement the twelve-month period. Plans also received rest of the state percentages with their plan excluded for comparison purposes. Plans were encouraged to review the reports, compare their results to previous data, and look at areas with changes from the previous reporting period to ensure data completeness. Also, during September, DOHs EQRO, IPRO, sent the third, and final, mailing of the 2023 MLTC Satisfaction Survey to eligible members. Finally, several other high-value MLTC deliverables including the 2022 MLTC Consumer Guides, the addition of 2022 MLTC measure results to publicly available data at Health Data NY, eMLTC tables, and the 2022 MLTC Report were in the final editing stages with release dates anticipated in October and November.

B. Quality Measurement in Medicaid Managed Care

Quality Measure Benchmarks 2021 (Measurement Year 2021)

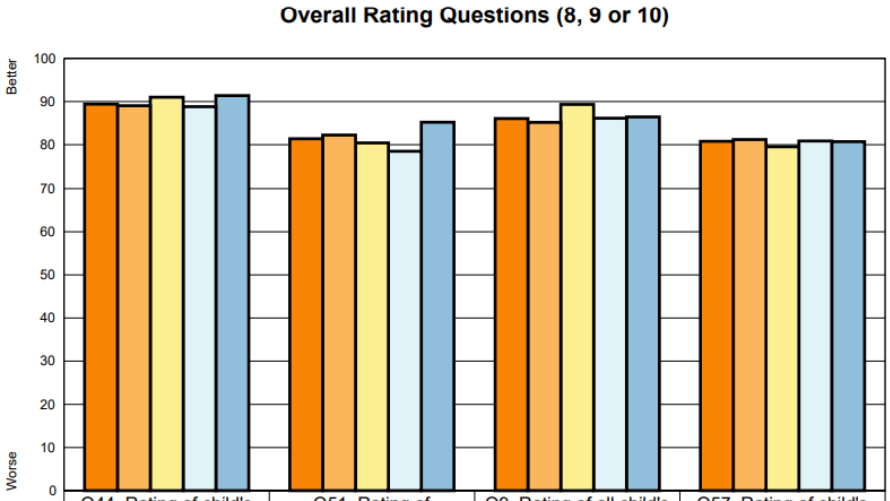
Quality of care remained high for MMC members for the Demonstration Year. In measurement year 2021, national benchmarks were available for 64 measures for Medicaid. Out of the 64 measures that NYS Medicaid plans reported, 80% of measures met or exceeded national benchmarks. NYS consistently met or exceeded 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). NYS 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.

2022 Satisfaction Survey

In the fall of 2022, the DOH conducted a satisfaction survey of children enrolled in MMC. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 child survey was administered children aged 0-17 years who were enrolled in Medicaid. The

administration methodology consisted of a three-wave mailing protocol, with telephone follow up for non-responders. The survey included 12 managed care plans in New York with a sample of 1,750 children per plan. Questionnaires were sent to 21,000 parents/caretakers of child members following a combined mail and web methodology during the period October 21, 2022, through January 20,2023, using a standardized survey procedure and questionnaire. A total of 2,467 eligible and complete responses were received resulting in a 13.1% response rate.

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.



	Q44. Rating of child's personal doctor	Q51. Rating of specialist child saw most often	Q9. Rating of all child's health care	Q57. Rating of child's health plan
MMC/CHP Statewide	89.41%	81.40%	86.07%	80.80%
Medicaid	89.03%	82.24%	85.20%	81.22%
CHP	91.00%	80.42%	89.36%	79.53%
CC - Negative	88.80%	78.50%	86.14%	80.87%
CC - Positive	91.37%	85.20%	86.46%	80.72%

2021 Quality Incentive for Medicaid Managed Care

The 2021 Quality Incentive Awards calculations were finalized in February 2023 which covered the measurement year period for 2021. The quality incentive is calculated on the percentage of total points a plan earned in the areas of Quality of Care and Experience of Care. Points are subtracted from the plan's total points if the plan had statements of deficiency in the Compliance category. Plans had the opportunity to earn ten bonus points by submitting a "COVID-19 Vaccination Equity Plan (CVEP)" that summarized their progress towards improving vaccination rates of their members through 2022. Plans were classified into five tiers based on the distribution of the final percentage points before the bonus points were awarded. Plans can only move up a maximum of one tier due to the CVEP bonus points. 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 2021 Incentive included three plans in Tier 1, one plan in Tier 2, seven plans in Tier 3, and two plans in Tier 5.

Quality Assurance Reporting Requirements (QARR)
In June, 26 health plans submitted reporting requirements to stakeholders as identified in QARR (e.g., NYS, IPRO, National Committee on Quality Assurance). Data was being collated and reviewed through the month. Data was published in November 2023.

C. Quality Improvement

External Quality Review
IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and providing data processing and analytical support to DOH. 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 (CHIP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

Annual EQRO Technical Reports
In Q1 DOH and the EQRO, IPRO were in the process of compiling data for the first draft of the 2021 EQR Annual technical reports. The first complete draft was completed during the second quarter and went through multiple DOH departments to make sure all data and narratives are exceptional. All parties have been reviewing the reports and adding comments throughout the quarter and the drafts were finalized by the end of March. At the start of the third quarter, the 2021 ATR reports were going through EDCC review and by April 28, 2023, the final reports were submitted to CMS. By the end of the third quarter, annual technical reports planning meetings have been conducted to go over the new 2022 technical reports.

By quarter 4 the EQRO and DOH have been in discussion for planning the 2022 Annual EQR Technical Reports. DOH suggested that the mainstream report will include Medicaid, HARP, and HIV SNP all in one report while the MLTC will be as separate report. DOH and IPRO started to draft timelines for both Mainstream and MLTC reports. IPRO has put together a rough draft with all three lines of business and DOH will be providing comments and edits throughout the document.

Provider Related and Access Activities
In Q1, the EQRO worked with DOH to begin verification of verification of plan provider directories. DOH began preparing enrollment data to begin the survey of PCP Access and Appointment Availability. Results from the first phase of the Plan Member Services survey were sent to plans in September 2022; the EQRO began phase two follow-up calls in Q1. During Q1, the DOH began to compile the data needed for the Access & Availability survey of High-Volume providers. Calls area anticipated to begin in the next quarter.

In Q2, the EQRO continued work with DOH on the verification of provider directories. For the Provider Access and Appointment Availability survey, DOH has received the data file for the enrollment numbers and the provider count and sent to the EQRO survey team. These calls will begin in Q3. IPRO finished the remaining calls for the MCP Member Services survey. During this quarter a new survey, the Essential Plan survey started and IPRO was working on a new data file.

In the beginning of the third quarter, The EQRO started Access survey. IPRO called more than 2,000 providers and was near about 50% completion of the goal. By May, the calls for the survey were completed and the data entry for the results was being completed. In June, all calls, data entry, and quality assurance were complete. IPRO will be in the process of drafting the final reports and completing analysis leading into the 4th quarter. IPRO sent the Member Services survey final reports to DOH throughout April and May. For the PCP ratio survey, calls began in May and were completed by June. IPRO began working with the vendor to capture data for the EP survey. IPRO drafted a project plan with a timeline for completion of the required tasks. In June, IPRO started the process of conducting calls for the EP survey along with the Quality Assurance for the calls. IPRO will be updating the project plan for the eligible population.

Lastly, in the 4th quarter, all calls were completed for the Access survey. IPRO is currently in the reporting phase of the survey. There was a total of 2,450 calls. IPRO is going through the calls and forming a final report. The member services survey has been completed and the survey results were given to DOH and they will provide any edits. IPRO went through and revised the reports for the Member Services survey. After editing the data, IPRO will be provide dates to discuss what was reported. The QA data entry was completed for the PCP rotation survey. There were more than 100 providers surveyed. During the survey IPRO noticed that the overall compliance rates were low between the non-routine, non- urgent and urgent calls. IPRO has sent over the data entry reports late August. By the end of September, DOH had completed their review of the survey results. The EP Survey group work was completed in July and the reports with findings have been sent to DOH for review. Currently, DOH is reviewing the second draft of the report. DOH will return with an approval in October.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). The PNDS collects network information from around 400 active networks in NYS. IPRO and their subcontractors- RMCI and Quest Analytics, 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 2023 PNDS submission deadline was Aug 2, 2023; plans submitted data based on version 11 of data dictionary.

Provider and Health Plan LOOK-UP:
The New York State Provider & Health Plan Look-Up website helps consumers in their health plan network and provider search. IPRO continues to refresh the data twice a month. The site has close to two million distinct users since its launch in May 2017.

PANEL:
Panel data submission opened on 8/1/2023 and yielded 7,297,306 rows of data (up ~1.43%). Technical assistance was provided by DOH and IPRO throughout the submission, particularly around new edits implemented. DOH provided detailed analytics to plans about failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)
The MLTC PIP had its PIP training during the first quarter, group calls were held during the beginning of November. The EQRO has received reports from all MLTC plans that summarize their PIP updates. All MLTC plans were notified the interim reports for the 2022-2023 PIP Cycle will be due on 1/31/2023.

During the second quarter, the MCP's received their reminders for the submissions for the first-year interim reports for the Social Determinants of Health (SDoH) PIP. Interim reports were due by the end of January. The EQRO received them by February 1, 2023, and anticipated completing the reviews by the end of March.

During the third quarter, the initial interim reports have been completed and reviewed. Some of the plans have received their reports back with revisions. By May, The EQRO reviewed all the reports and by June all reports were given back to the plans.

By the end of the fourth quarter, all Interim reports were completed. One plan needed to fix small errors and was submitted late. IPRO internally deliberated on a new topic for the 2024-2025 PIP cycle for the MLTC plans. The group is considering topics for the upcoming PIP cycle. The drafting of the background report will begin in October.

Member Satisfaction Survey
The MLTC Satisfaction Survey was in preparation by the end of the first quarter. The EQRO sent the survey for translation and is working to prepare for mailing. The surveys will be printed and sent out for mailing in the beginning of the second quarter.

At the beginning of Q2, the EQRO made a sample of members in which they will receive the Member Satisfaction Survey. By February the English version of the survey was mailed. By the end of March, the English version of the survey was mailed, and the secondary languages (Spanish, Russian, and Chinese) followed.

During the third quarter there was a response rate of 8% to 9%. By May, the response rate rose to 10.6%. The EQRO started to draft the data analysis plan for the survey. By June, the second mailing was sent out. IPRO, the EQRO, noted that the response rate rose to 11.7%. In the fourth quarter, IPRO sent out a third mailing for the satisfaction survey. By the end of August, the response rate stood at 17.5% and by the end of September, the response rate will be at 19%.

Focused Clinical Study
For the MLTC Focus Clinical Study, the EQRO completed 11 telehealth and in-person assessments by the end of the first quarter 12/31/2022. In the second quarter there will be more

nurses available and additional member sample size. The EQRO will continue to recruit members to increase the number of assessments to validate.

The ongoing focused study seeks to validate and assess interrater reliability of telehealth assessment as compared to in-person assessments for home care services. This study continues with ongoing recruitment of new members for dual assessments (telehealth and in-person). At the end of Q2, 12 completed pirs of assessments had been recorded. This work will continue in Q3.

At the start of the third quarter the EQRO has conducted 14 completed assessment pairs. By May, the number of completed assessments stands. IPRO has had trouble with members going through with conducting the telehealth and in-person assessments. In June, the assessment total reached 15 assessment pairs completed. IPRO wants to make at least 20 assessment pairs completed by the end of the study.

During the fourth quarter from July to September there were 16 completed pairs. IPRO has made many appointments for in-person and telehealth assessments but majority of them were either cancelled and/or one of the assessments were completed. Throughout the quarter IPRO has provided new schedules for nurses to accommodate for assessment schedules.

Quality Measurement

During the first quarter the EQRO had a meeting with the certified CAHPS vendor (DataStat) to discuss planning for the 2022 CAHPS survey. The DOH prepared the survey materials and sample. DataStat notified DOH that the survey was sent on October 21st, 2022, and the second mailing will be sent out in November. A third mailing will be sent during the second quarter. The annual performance measurement data collection cycle began in early October with the technical workshop for managed care plans. The EQRO led the workshop to present the requirements for plan data collection and submission.

For the second quarter quality measurement was quiet. Throughout the second quarter the EQRO has spent its time communicating with DOH to update their contact lists for their meeting with NCQA. By March, IPRO configured a website page that allows the plans and vendors to upload data to the site. The plans and vendors will be notified in April. The CAHPS – Kids survey is in its third mailing.

In the beginning of the third quarter, the CAHPS kids final report was posted to the DOH website. IPRO and DOH had a meeting with DataStat to discuss the next CAHPS survey. In May, the QARR data and analytics team were working to prepare for the June submission. By June 15, 2023, IPRO received all patient level files, enhancement files, QHP, and CAHPS files from the plans and vendors. IPRO will review the documentation and will report any significant findings to DOH.

All enhancement files have been reviewed and concatenated. During the fourth quarter, IPRO received the corrected patient level data in July from NCQA. IPRO sent the data files to DOH as well as the utilization and resubmission data files from NCQA. By the end of the quarter IPRO will be getting ready for the QARR conference. IPRO has submitted the drafts slides and will provide edits. The conference will be held in mid-October. The CAHPS Kids report is completed and is posted to the CAHPS site. DOH and IPRO had a kickoff meeting with DataStat in

September. The discussion was for the CAHPS Adult survey, and DataStat will provide their proposal in the next quarter.

PIPs for MMCs:

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

On October 27, 2021, a WebEx meeting with MMC and HIV SNP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The PIP Proposals were submitted by December 8, 2021. The PIP Proposals were reviewed and finalized by IPRO and NYSDOH. The approved interventions were implemented in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 15, 2022. The updates were reviewed and approved by IPRO and DOH. Dental PIP Interim reports were submitted by the plans to IPRO by 1/30/2023. IPRO and DOH reviewed and approved them. IPRO conducted plan-specific oversight calls with the plans in January, May, and September 2023. Prior to the oversight calls the plans submitted updates on their intervention tracking measures. WebEx meetings were conducted with all plans participating and selected plans presented on their PIP progress and lessons learned. These WebEx meetings were held on April 27, July 28, and September 28, 2023.

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 approved interventions were implemented in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 29, 2022. The updates were reviewed and approved by IPRO and DOH. HARP PIP Interim reports were submitted by the plans to IPRO by April 28, 2023. IPRO and DOH reviewed and approved them. IPRO conducted plan-specific oversight calls with the plans in February and June 2023. October 2023 oversight calls are scheduled. Prior to the oversight calls the plans submit updates on their intervention tracking measures. Webinars were conducted with all plans participating and selected plans presented on their PIP progress and lessons learned. These webinars were held on May 17 and August 17, 2023. An October 24, 2023, WebEx meeting is planned for selected HARP plans to present their PIP progress and lessons learned.

Breast Cancer Selective Contracting

Staff completed the Breast Cancer Selective Contracting process for contract year 2023-2024. 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 FFS payments can be appropriately restricted, as well as, sharing the list with MMC health

plans' Chief Executive Officers and Medical Directors via DOH Integrated Health Alerting and Notification System (IHANS).

In total, the annual review identified 326 facilities. Facility designations were as follows: 121 high-volume facilities, 5 low-volume unrestricted facilities, and 200 low-volume restricted facilities.

Staff also completed the summer review of breast cancer surgical volume data. Provisional volume designations for contract year 2024-2025 were shared with facilities' SPARCS coordinators in June 2023. 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: 4 (7/1/2023-9/30/2023)

As of September 2023, there were 8,947 NCQA-recognized Patient-Centered Medical Home (PCMH) providers and 2,194 practices in NYS. All these providers enrolled recognition under the NYS PCMH standards, which is an exclusive NCQA program for NYS released on April 1, 2018. To achieve NYS PCMH recognition, practices must meet all requirements of the NCQA recognition program, which includes implementing both core criteria and elective criteria. The NYS PCMH program stipulates that practices implement the core criteria as defined by NCQA and meet the elective criteria requirement in part through the implementation of 11 NYS-required criteria which focus on NYS priorities such as BH, care management, population health, and health information technology capabilities. Of the 8,947 providers recognized in September 2023, 16 were new to the NYS PCMH program.

The incentive rate for the New York Medicaid PCMH Statewide Incentive Payment Program as of September 2023 is $6.00 PMPM.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2023 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/.

Annual: 10/1/2022-9/30/2023

The PCMH 2014 and 2017 recognition standards expired before the demonstration year. Starting in May 2021, NYS PCMH became the only standard for NYS practices. Throughout the year, the program remained relatively stable with a slight decrease in volume. In October 2022, there were 9,306 NCQA-recognized 2018 PCMH providers in New York State, this number reduced to 8,947 by the end of September 2023. The number of NCQA-recognized PCMH practices in New York State also declined over the year, dropping from 2,302 in October 2022 to 2,194 in September 2023.

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

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

The State is also awaiting further guidance on two timely filing waivers submitted to correct reporting errors noted in previous quarterly reports. These expenditures, though not currently represented on the Schedule C, are included in the Budget Neutrality reporting tool workbook to accurately reflect the state's Budget Neutrality position:

- As detailed in STC X.10, the State identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the October 1, 2011, through March 31, 2016, period. The audit was completed over the summer of 2018. A final audit report was submitted to CMS on September 19, 2019, with CMS confirming in a subsequent discussion on October 10, 2019, that all corrective action requirements outlined in the STCs have been satisfied. The State has addressed all audit findings, however, entry of corrected data for F-SHRP DY6 into the Medicaid Budget and Expenditure System (MBES) is pending approval of a timely filing waiver.
- The State has also requested a timely filing waiver to address an issue with reporting for DY18 Q1-4 and DY19 Q1 resulting from an error in the query language used to pull data for this time period which resulted in the exclusion of F-SHRP counties for these quarters. This error was not uncovered until all DY18 quarters were processed, allowing for comparisons to previous full data years that had already been reported, and the source of the issue was not identified until DY19Q1 was already processed.

X. Other

A. Transformed Medicaid Statistical Information Systems (T-MSIS)

NYS Compliance

The State sends the following files to CMS monthly:

- Eligibility
- Provider
- Managed Care
- Third Party Liability
- Inpatient Claims
- Long-Term Care Claims
- Prescription Drug Claims
- Other Types of Claims

The State is current in its submission of these files. NYS has been addressing the data quality issues associated with the new Outcomes Based Assessment (OBA) compliance criteria.

Status as of reporting month of September 2023:

Critical-Priority:	100%	(Target 100%)
High-Priority:	98%	(Target ≥ 99%)
Expenditures:	99%	(Target ≥ 95%)

As of the September 2023 reporting month, the State data meets the Critical-Priority and Expenditures criteria target of OBA and is 1% below the target for High-Priority criterion. The state is actively working on addressing the identified high priority issues to meet the High-Priority criterion of OBA.

NYS continues to work closely with CMS and its analytics vendors to define, identify and prioritize new issues, and engage in efforts to resolve identified data quality issues.

To help facilitate resolution of identified data issues, the state has instituted a Data Governance workgroup for T-MSIS. The group will provide support in addressing identified data quality issues and specific processes and policies that are unique to NY under its approved Medicaid plan. Where appropriate, the data governance group will supplement and support SME (subject matter experts) efforts to provide explanations and documentation to better understand reporting nuances related to the state policies and programs (under the State's approved Medicaid plan).

In addition, the State is targeting to implement the Phase one File Layout changes in **November 2023.** This change includes adding, renaming, deprecating, and modifying data element segments and types. This will make the files compliant with the newer DDv3.0.0 layout. CMS requires the states to implement this change by December 31, 2023. UAT (User Acceptance Testing) is currently in progress.

In October 2023, NYS also initiated and is currently engaged in the T-MSIS historical file(s) resubmissions process. Reporting period December 2018 through August 2023 (98 months) will be covered as part of this project. The historical files resubmission efforts are expected to continue through April 2024.

NYS continues to work closely with CMS and its analytics vendors to define, identify and prioritize new issues.

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.

The State is planning to conduct a Public Forum in early 2024.

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

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

Uploaded to PMDA: December 29, 2023

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	16	0	0	0	2	0	8	3	3	5834	0.27%
AgeWell MAP	2	0	0	0	0	0	0	1	1	123	1.63%
Archcare Community Life	64	2	0	0	15	8	21	18	0	5858	1.09%
Archcare PACE	0	0	0	0	0	0	0	0	0	787	0.00%
Catholic Health-LIFE	15	0	7	0	0	0	3	5	0	234	6.41%
Centerlight PACE	115	0	0	0	0	0	48	58	9	6252	1.84%
Centers Plan for Healthy Living	980	1	0	1	42	4	270	662	0	51054	1.92%
Centers Plan for Healthy Living MAP	39	0	0	0	7	0	9	23	0	1623	2.40%
Complete Senior Care	2	0	0	0	0	0	1	1	0	132	1.52%
Eddy SeniorCare	0	0	0	0	0	0	0	0	0	347	0.00%
Elant Choice (EverCare)	0	0	0	0	0	0	0	0	0	779	0.00%
Elderplan MAP	8	0	0	0	6	0	1	1	0	3421	0.23%
Elderserve	493	3	1	0	2	10	74	287	116	16598	2.97%
Elderserve MAP	7	0	0	0	0	1	1	5	0	207	3.38%
Elderwood	107	0	0	0	0	0	10	31	66	1129	9.48%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	53921	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	147	0.00%
Extended	20	0	0	0	0	0	13	7	0	1861	1.07%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	796	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	153	0.00%
Fidelis Care at Home	36	0	0	0	1	1	11	23	0	16772	0.21%
Fidelis MAP	2	0	0	0	0	0	0	2	0	1053	0.19%
Hamaspik	166	0	0	0	2	3	68	75	18	5657	2.93%
Hamaspik MAP	43	0	0	1	0	0	36	4	2	831	5.17%
Healthfirst CompleteCare	217	0	0	1	8	7	53	147	1	26161	0.83%
HomeFirst, Inc. (Elderplan)	20	0	0	0	19	0	0	0	1	19840	0.58%
Icircle	7	0	0	0	6	1	0	0	0	3547	0.20%
Independent Living for Seniors (ILS/ElderOne)	2	0	0	0	0	0	0	0	2	749	0.27%

Independent Living Services of CNY (PACE CNY)	23	0	0	1	0	0	7	15	0	541	4.25%
Kalos ErieNiagara DBA: First Choice Health	0	0	0	0	0	0	0	0	0	624	0.00%
MetroPlus MAP	2	0	0	0	0	0	1	1	0	141	1.42%
MetroPlus	4	0	0	0	0	1	1	2	0	1428	0.28%
Montefiore	0	0	0	0	0	0	0	0	0	1303	0.00%
Prime	46	0	0	0	2	3	8	33	0	585	7.86%
Senior Health Partners	62	0	0	0	2	0	12	48	0	9119	0.68%
Senior Network Health, LLC	5	0	0	0	0	0	1	4	0	335	1.49%
Senior Whole Health	0	0	0	0	0	0	0	0	0	26626	0.00%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	189	0.00%
Total Senior Care	7	0	0	0	0	0	3	4	0	133	5.26%
Village Care	200	0	0	0	23	0	28	149	0	18722	1.07%
Village Care MAP	62	0	0	0	12	1	7	42	0	2626	2.36%
VNA Homecare Options (Nascentia Health Options)	231	0	0	3	2	4	97	125	0	4461	5.18%
VNS Choice MAP TOTAL	58	1	0	0	5	1	12	39	0	3798	1.53%
VNS Choice MLTC	379	0	0	0	10	2	73	294	0	23690	1.60%
total	3440	7	8	7	166	47	877	2109	219	320187	1.07%

Managed Long Term Care Partial Capitation Plan Enrollment Oct 2022 to Sep 2023												
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Plan Name	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Aetna Better Health	5459	5514	5550	5585	5597	5620	5671	5707	5732	5791	5825	5885
AgeWell New York	52	14	0	0	0	0	0	0	0	0	0	0
ArchCare Community Life	5142	5285	5381	5435	5499	5562	5621	5693	5771	5824	5865	5885
Centers Plan for Healthy Living	47775	48144	48662	49023	49090	49581	50096	50421	50625	50814	51037	51311
Elant	873	862	865	866	845	846	840	809	798	780	776	782
Elderplan	15885	16236	16781	17169	17457	17867	18266	18730	19022	19460	19877	20184
Elderserve	15608	15789	15950	15978	16041	16104	16236	16293	16371	16452	16615	16728
Elderwood	1064	1081	1093	1082	1076	1079	1077	1093	1115	1130	1137	1121
Extended MLTC	5526	5607	5657	5660	5650	5688	5745	5773	5700	5583	0	0
Fallon Health Weinberg (TAIP)	829	834	834	836	831	835	825	813	812	806	799	783
Fidelis Care at Home	17278	17124	17239	17329	17070	16998	16931	16873	16746	16688	16774	16853
Hamaspik Choice	1954	1943	1953	1940	1938	1932	1937	1932	1956	1982	7516	7474
HealthPlus- Amerigroup	5426	6795	50128	50655	50970	51189	51622	52192	52796	53251	54024	54488
iCircle Services	3527	3519	3497	3497	3461	3466	3468	3495	3517	3539	3538	3563
Integra	43954	43043	0	0	0	0	0	0	0	0	0	0
Kalos Health- Erie Niagara	523	539	543	543	551	565	571	576	588	599	625	647
MetroPlus MLTC	1325	1321	1331	1338	1344	1348	1358	1351	1374	1382	1430	1472
Montefiore HMO	1383	1370	1370	1361	1340	1338	1331	1325	1311	1313	1295	1302
Prime Health Choice	560	568	574	573	572	580	584	587	588	582	585	587
Senior Health Partners	9190	9211	9263	9263	9199	9212	9201	9185	9159	9122	9117	9120
Senior Network Health	333	330	331	327	313	315	313	317	324	327	336	342
Senior Whole Health	24107	24146	26110	26065	25961	26093	26229	26370	26325	26394	26603	26882
Village Care	15533	15988	16450	16676	16763	16888	17173	17544	17913	18329	18682	19156
VNA HomeCare Options	3575	3621	3683	3728	3768	3732	3906	4059	4200	4305	4482	4596
VNS Choice	22672	23017	23312	23382	23363	23369	23477	23577	23589	23703	23727	23640
Total	**249,553**	**251,901**	**256,557**	**258,311**	**258,699**	**260,207**	**262,478**	**264,715**	**266,332**	**268,156**	**270,665**	**272,801**

Managed Long Term Care MAP Enrollment Oct 2022 to Sep 2023												
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Plan Name	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Fidelis	500	494	619	618	754	840	878	904	956	1035	1050	1075
Hamaspik	520	543	586	633	664	699	746	778	798	834	831	829
Agewell	94	97	108	118	116	118	121	117	116	122	125	123
Centers	1323	1286	1250	1390	1446	1461	1463	1524	1560	1592	1642	1634
Elderplan	3131	3125	3131	3151	3169	3191	3243	3301	3331	3379	3422	3462
Elderserve	126	140	152	167	171	175	178	185	193	196	205	219
Healthfirst Complete Care	22925	22993	23265	23737	24026	24316	24657	25098	25509	25789	26159	26536
Healthplus	186	185	206	197	192	182	179	172	167	166	147	127
Metroplus	32	36	41	50	71	79	87	109	125	131	142	149
Senior Whole Health	144	139	138	140	143	147	153	169	170	179	188	201
VNS	3094	3055	2988	3189	3254	3385	3485	3575	3634	3707	3802	3886
Village Care	2689	2624	2577	2625	2593	2572	2553	2578	2591	2594	2635	2650
Total	**34764**	**34717**	**35061**	**36015**	**36599**	**37165**	**37743**	**38510**	**39150**	**39724**	**40348**	**40891**

Managed Long Term Care PACE Enrollment Oct 2022 to Sep 2023												
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Plan Name	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Archcare	668	675	670	695	711	712	715	742	765	782	786	793
CHS Buffalo Life	242	241	247	241	236	238	240	239	233	235	236	231
Complete Senior Care	124	125	125	124	126	130	127	129	128	131	130	134
Comprehensive Care Management	4934	5307	5523	5698	5838	5832	5873	6032	6116	6156	6278	6322
Eddy Senior Care	320	325	317	316	318	318	319	335	338	345	351	344
Fallon Health Weinberg PACE	139	140	137	140	142	146	145	147	149	152	155	152
Independent Living For Seniors	736	730	734	731	733	736	730	736	734	741	753	754
Pace CNY	508	511	523	530	525	526	523	519	530	533	542	548
Total Senior Care	136	132	132	130	130	128	130	128	133	133	132	133
Total	**7807**	**8186**	**8408**	**8605**	**8759**	**8766**	**8802**	**9007**	**9126**	**9208**	**9363**	**9411**

Managed Long Term Care FIDA-IDD Enrollment Oct 2022 to Sep 2023												
	Oct-22	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1668	1677	1685	1704	1699	1714	1710	1720	1724	1733	1728	1723