



New York State Medicaid Managed Long-Term Care 2023 External Quality Review Annual Technical Report

**Medicaid Advantage Plus Plans
Partial Capitation Plans
Program of All-Inclusive Care for Elderly Plans**

April 2025

**Prepared on behalf of:
The New York State Department of Health**

ipro.org

Per Title 42 CFR 438.364(a)(7), no managed care plan was exempt from the external quality review activities conducted in 2023.

Table of Contents

Table of Contents	2
List of Tables	12
About This Report.....	25
External Quality Review and Annual Technical Report Requirements	26
2023 External Quality Review	27
New York State’s Managed Care Programs and Quality Strategy for Medicaid and Child Health Plus	29
History of New York State’s Managed Care Programs	29
New York State’s Medicaid and Child Health Plus Quality Strategy	29
IPRO’s Assessment of New York State’s Medicaid and Child Health Plus Quality Strategy	44
Recommendations to the New York State Department of Health	45
Medicaid Managed Long-Term Care Plan Profiles.....	46
External Quality Review Activity 1. Validation of Performance Improvement Projects.....	49
Technical Summary – Validation of Performance Improvement Projects	50
Objectives	50
Technical Methods for Data Collection and Analysis	51
Description of Data Received.....	52
Comparative Results	52
External Quality Review Activity 2. Validation of Performance Measures	59
Technical Summary – Validation of Performance Measures	60
Objectives	60
Technical Methods of Data Collection and Analysis.....	60
Description of Data Obtained	62
Comparative Results	62
External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards	66
Technical Summary – Review of Compliance with Medicaid and Children’s Health Insurance Program Standards.....	67
Objectives	67
Technical Methods of Data Collection and Analysis.....	68
Description of Data Obtained	71
Comparative Results	72
External Quality Review Activity 4. Validation of Network Adequacy	80
Technical Summary – Validation of Network Adequacy	81
Objectives	81
Technical Methods for Data Collection and Analysis	89
Description of Data Received.....	91
Comparative Results	92
External Quality Review Activity 6. Administration of Quality-of-Care Survey	94

Technical Summary – Administration of Quality-of-Care Surveys 95

- Objectives 95
- Technical Methods of Data Collection and Analysis..... 95
- Description of Data Obtained 96
- Comparative Results..... 96

Managed Long-Term Care Plan-Level Reporting 98

Medicaid Advantage Plus Managed Long-Term Care Plans..... 101

AgeWell 102

- Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 102
- Performance Improvement Project Summaries and Results 102
- Performance Measure Results..... 104
- Compliance with Medicaid and Children’s Health Insurance Program Standards Results 104
- Network Adequacy Results 105
- Quality-of-Care Survey Results – Member Experience 105
- Strengths, Opportunities for Improvement, and Recommendations 105

Centers Plan 107

- Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 107
- Performance Improvement Project Summaries and Results 109
- Performance Measure Results..... 110
- Compliance with Medicaid and Children’s Health Insurance Program Standards Results 110
- Network Adequacy Results 110
- Quality-of-Care Survey Results – Member Experience 111
- Strengths, Opportunities for Improvement, and Recommendations 111

Elderplan..... 114

- Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 114
- Performance Improvement Project Summaries and Results 116
- Performance Measure Results..... 118
- Compliance with Medicaid and Children’s Health Insurance Program Standards Results 118
- Network Adequacy Results 119
- Quality-of-Care Survey Results – Member Experience 119
- Strengths, Opportunities for Improvement, and Recommendations 120

Empire BCBS HealthPlus..... 123

- Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 123
- Performance Improvement Project Summaries and Results 124
- Performance Measure Results..... 126
- Compliance with Medicaid and Children’s Health Insurance Program Standards Results 126
- Network Adequacy Results 127
- Quality-of-Care Survey Results – Member Experience 127
- Strengths, Opportunities for Improvement, and Recommendations 127

Fidelis Care 130

- Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 130
- Performance Improvement Project Summaries and Results 131

Performance Measure Results..... 133

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 133

Network Adequacy Results 134

Quality-of-Care Survey Results – Member Experience 135

Strengths, Opportunities for Improvement, and Recommendations 135

Hamaspik 138

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 138

Performance Improvement Project Summaries and Results 140

Performance Measure Results..... 142

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 142

Network Adequacy Results 143

Quality-of-Care Survey Results – Member Experience 143

Strengths, Opportunities for Improvement, and Recommendations 144

MetroPlus 147

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 147

Performance Improvement Project Summaries and Results 149

Performance Measure Results..... 151

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 151

Network Adequacy Results 152

Quality-of-Care Survey Results – Member Experience 152

Strengths, Opportunities for Improvement, and Recommendations 152

MHI Healthfirst..... 155

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 155

Performance Improvement Project Summaries and Results 157

Performance Measure Results..... 159

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 159

Network Adequacy Results 160

Quality-of-Care Survey Results – Member Experience 160

Strengths, Opportunities for Improvement, and Recommendations 161

RiverSpring..... 164

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 164

Performance Improvement Project Summaries and Results 165

Performance Measure Results..... 167

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 167

Network Adequacy Results 168

Quality-of-Care Survey Results – Member Experience 168

Strengths, Opportunities for Improvement, and Recommendations 168

Senior Whole Health..... 171

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 171

Performance Improvement Project Summaries and Results 172

Performance Measure Results..... 174

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 174

Network Adequacy Results 175

Quality-of-Care Survey Results – Member Experience 175
Strengths, Opportunities for Improvement, and Recommendations 175

VillageCare 178

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 178
Performance Improvement Project Summaries and Results 179
Performance Measure Results..... 181
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 181
Network Adequacy Results 181
Quality-of-Care Survey Results – Member Experience 182
Strengths, Opportunities for Improvement, and Recommendations 182

VNS Health 185

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 185
Performance Improvement Project Summaries and Results 186
Performance Measure Results..... 188
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 188
Network Adequacy Results 189
Quality-of-Care Survey Results – Member Experience 190
Strengths, Opportunities for Improvement, and Recommendations 190

Partial Capitation Managed Long-Term Care Plans 193

Aetna 194

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 194
Performance Improvement Project Summaries and Results 195
Performance Measure Results..... 197
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 197
Network Adequacy Results 198
Quality-of-Care Survey Results – Member Experience 199
Strengths, Opportunities for Improvement, and Recommendations 199

ArchCare 202

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 202
Performance Improvement Project Summaries and Results 203
Performance Measure Results..... 205
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 205
Network Adequacy Results 206
Quality-of-Care Survey Results – Member Experience 207
Strengths, Opportunities for Improvement, and Recommendations 207

Centers Plan 210

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 210
Performance Improvement Project Summaries and Results 211
Performance Measure Results..... 213
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 214
Network Adequacy Results 215
Quality-of-Care Survey Results – Member Experience 215
Strengths, Opportunities for Improvement, and Recommendations 216

Elderplan..... 219
Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 219
Performance Improvement Project Summaries and Results 221
Performance Measure Results..... 223
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 224
Network Adequacy Results 226
Quality-of-Care Survey Results – Member Experience 226
Strengths, Opportunities for Improvement, and Recommendations 227

Elderwood..... 229
Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 229
Performance Improvement Project Summaries and Results 229
Performance Measure Results..... 231
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 231
Network Adequacy Results 234
Quality-of-Care Survey Results – Member Experience 234
Strengths, Opportunities for Improvement, and Recommendations 235

Empire BCBS HealthPlus..... 237
Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 237
Performance Improvement Project Summaries and Results 238
Performance Measure Results..... 240
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 240
Network Adequacy Results 241
Quality-of-Care Survey Results – Member Experience 241
Strengths, Opportunities for Improvement, and Recommendations 242

EverCare 245
Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 245
Performance Improvement Project Summaries and Results 245
Performance Measure Results..... 247
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 247
Network Adequacy Results 248
Quality-of-Care Survey Results – Member Experience 249
Strengths, Opportunities for Improvement, and Recommendations 249

Extended MLTC 252
Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 252
Performance Improvement Project Summaries and Results 252
Performance Measure Results..... 254
Compliance with Medicaid and Children’s Health Insurance Program Standards Results 255
Network Adequacy Results 255
Quality-of-Care Survey Results – Member Experience 256
Strengths, Opportunities for Improvement, and Recommendations 256

Fallon Health 258
Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 258
Performance Improvement Project Summaries and Results 258

Performance Measure Results..... 259

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 260

Network Adequacy Results 260

Quality-of-Care Survey Results – Member Experience 261

Strengths, Opportunities for Improvement, and Recommendations 262

Fidelis Care 264

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 264

Performance Improvement Project Summaries and Results 265

Performance Measure Results..... 267

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 267

Network Adequacy Results 268

Quality-of-Care Survey Results – Member Experience 269

Strengths, Opportunities for Improvement, and Recommendations 269

Hamaspik 272

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 272

Performance Improvement Project Summaries and Results 273

Performance Measure Results..... 275

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 276

Network Adequacy Results 277

Quality-of-Care Survey Results – Member Experience 277

Strengths, Opportunities for Improvement, and Recommendations 278

iCircle 281

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 281

Performance Improvement Project Summaries and Results 283

Performance Measure Results..... 285

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 285

Network Adequacy Results 286

Quality-of-Care Survey Results – Member Experience 287

Strengths, Opportunities for Improvement, and Recommendations 287

Kalos Health 290

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 290

Performance Improvement Project Summaries and Results 291

Performance Measure Results..... 293

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 293

Network Adequacy Results 294

Quality-of-Care Survey Results – Member Experience 295

Strengths, Opportunities for Improvement, and Recommendations 295

MetroPlus 298

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 298

Performance Improvement Project Summaries and Results 299

Performance Measure Results..... 301

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 301

Network Adequacy Results 303

Quality-of-Care Survey Results – Member Experience 303

Strengths, Opportunities for Improvement, and Recommendations 304

Montefiore..... 307

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 307

Performance Improvement Project Summaries and Results 307

Performance Measure Results..... 309

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 309

Network Adequacy Results 311

Quality-of-Care Survey Results – Member Experience 311

Strengths, Opportunities for Improvement, and Recommendations 312

Nascentia 314

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 314

Performance Improvement Project Summaries and Results 316

Performance Measure Results..... 317

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 317

Network Adequacy Results 318

Quality-of-Care Survey Results – Member Experience 319

Strengths, Opportunities for Improvement, and Recommendations 320

Prime Health 323

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 323

Performance Improvement Project Summaries and Results 323

Performance Measure Results..... 325

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 325

Network Adequacy Results 327

Quality-of-Care Survey Results – Member Experience 328

Strengths, Opportunities for Improvement, and Recommendations 329

RiverSpring..... 332

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 332

Performance Improvement Project Summaries and Results 334

Performance Measure Results..... 335

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 336

Network Adequacy Results 337

Quality-of-Care Survey Results – Member Experience 337

Strengths, Opportunities for Improvement, and Recommendations 338

Senior Health Partners..... 341

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 341

Performance Improvement Project Summaries and Results 342

Performance Measure Results..... 344

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 344

Network Adequacy Results 345

Quality-of-Care Survey Results – Member Experience 346

Strengths, Opportunities for Improvement, and Recommendations 347

Senior Network Health..... 350

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 350

Performance Improvement Project Summaries and Results 350

Performance Measure Results..... 352

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 352

Network Adequacy Results 353

Quality-of-Care Survey Results – Member Experience 354

Strengths, Opportunities for Improvement, and Recommendations 354

Senior Whole Health..... 357

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 357

Performance Improvement Project Summaries and Results 358

Performance Measure Results..... 360

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 360

Network Adequacy Results 361

Quality-of-Care Survey Results – Member Experience 361

Strengths, Opportunities for Improvement, and Recommendations 362

VillageCare 365

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 365

Performance Improvement Project Summaries and Results 367

Performance Measure Results..... 369

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 369

Network Adequacy Results 370

Quality-of-Care Survey Results – Member Experience 371

Strengths, Opportunities for Improvement, and Recommendations 371

VNS Health 374

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 374

Performance Improvement Project Summaries and Results 376

Performance Measure Results..... 378

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 378

Network Adequacy Results 379

Quality-of-Care Survey Results – Member Experience 381

Strengths, Opportunities for Improvement, and Recommendations 381

Program of All-Inclusive Care for the Elderly Managed Long-Term Care Plans 384

ArchCare 385

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 385

Performance Improvement Project Summaries and Results 387

Performance Measure Results..... 388

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 388

Network Adequacy Results 389

Quality-of-Care Survey Results – Member Experience 390

Strengths, Opportunities for Improvement, and Recommendations 390

Catholic Health 393

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 393

Performance Improvement Project Summaries and Results 395

Performance Measure Results..... 397

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 398

Network Adequacy Results 398

Quality-of-Care Survey Results – Member Experience 399

Strengths, Opportunities for Improvement, and Recommendations 400

CenterLight 402

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 402

Performance Improvement Project Summaries and Results 404

Performance Measure Results..... 406

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 406

Network Adequacy Results 407

Quality-of-Care Survey Results – Member Experience 408

Strengths, Opportunities for Improvement, and Recommendations 408

Complete Senior Care 411

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 411

Performance Improvement Project Summaries and Results 412

Performance Measure Results..... 414

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 414

Network Adequacy Results 415

Quality-of-Care Survey Results – Member Experience 416

Strengths, Opportunities for Improvement, and Recommendations 417

Eddy SeniorCare 420

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 420

Performance Improvement Project Summaries and Results 421

Performance Measure Results..... 423

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 423

Network Adequacy Results 424

Quality-of-Care Survey Results – Member Experience 425

Strengths, Opportunities for Improvement, and Recommendations 426

ElderONE 429

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 429

Performance Improvement Project Summaries and Results 430

Performance Measure Results..... 432

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 432

Network Adequacy Results 433

Quality-of-Care Survey Results – Member Experience 434

Strengths, Opportunities for Improvement, and Recommendations 434

Fallon Health 437

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 437

Performance Improvement Project Summaries and Results 439

Performance Measure Results..... 440

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 440

Network Adequacy Results 442

Quality-of-Care Survey Results – Member Experience 442

Strengths, Opportunities for Improvement, and Recommendations 443

PACE CNY 446

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 446

Performance Improvement Project Summaries and Results 448

Performance Measure Results..... 449

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 449

Network Adequacy Results 450

Quality-of-Care Survey Results – Member Experience 450

Strengths, Opportunities for Improvement, and Recommendations 451

Total Senior Care 453

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations .. 453

Performance Improvement Project Summaries and Results 454

Performance Measure Results..... 456

Compliance with Medicaid and Children’s Health Insurance Program Standards Results 456

Network Adequacy Results 457

Quality-of-Care Survey Results – Member Experience 458

Strengths, Opportunities for Improvement, and Recommendations 458

Appendix A - Programs of All-Inclusive Care for the Elderly (PACE)..... 461

Audit Overview 461

List of Tables

Table 1: Managed Long-Term Care External Quality Review Activities Performed for 2023	25
Table 2: External Quality Review Activity Descriptions and Applicable Protocols.....	27
Table 3: New York State’s Medicaid and Child Health Plus Quality Strategy Goals	30
Table 4: New York State’s Medicaid and Child Health Plus Quality Strategy Goals and Objectives, January 2023-December 2025	31
Table 5: New York State’s Medicaid and Child Health Plus Quality Strategy Metrics and Performance Rates.....	33
Table 6: Managed Long-Term Care Plan Types	46
Table 7: Managed Long-Term Care Profiles	47
Table 8: Required Performance Improvement Project Indicators, 2022-2023	51
Table 9: Medicaid Advantage Plus Performance Improvement Project Validation Findings, Measurement Year 2023	53
Table 10: Partial Capitation Performance Improvement Project Validation Findings, Measurement Year 2023 ...	54
Table 11: Program of All-Inclusive Care for the Elderly Performance Improvement Project Validation Findings, Measurement Year 2023	55
Table 12: Medicaid Advantage Plus Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2023	56
Table 13: Partial Capitation Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2023	57
Table 14: Program of All-Inclusive Care for the Elderly Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2023	58
Table 15: Community Health Assessment Categories and Measures.....	61
Table 16: Medicaid Advantage Plus Performance Measure Results	63
Table 17: Partial Capitation Performance Measure Results.....	64
Table 18: Program of All-Inclusive Care for the Elderly Performance Measure Results.....	65
Table 19: Medicaid Advantage Plus Managed Care Plan Compliance Survey Results	73
Table 20: Partial Capitation Managed Care Plan Compliance Survey Results	74
Table 21: Program of All-Inclusive Care for the Elderly Managed Care Plan Compliance Survey Results.....	78
Table 22: New York Managed Long-Term Care Medicaid Advantage Plus Travel Time Standards for Managed Care Plans	83
Table 23: New York Managed Long-Term Care Partial Capitation Travel Time Standards for Managed Care Plans	83
Table 24: New York Managed Long-Term Care Program of All-Inclusive Care for the Elderly Travel Time Standards for Managed Care Plans	83
Table 25: New York Service Delivery Network Standards for Partial Capitation Managed Long-Term Care Plans.	83
Table 26: New York Service Delivery Network Standards for Medicaid Advantage Plus Plans	85
Table 27: New York Service Delivery Network Standards for Program of All-Inclusive Care for the Elderly Plans.	87

Table 28: Service Delivery Network Gap Types..... 91

Table 29: Medicaid Advantage Plus Evaluation of Network Adequacy, Quarter 4, 2023..... 92

Table 30: Partial Capitation Evaluation of Network Adequacy, Quarter 4, 2023 92

Table 31: Program of All-Inclusive Care for the Elderly Evaluation of Network Adequacy, Quarter 4, 2023 93

Table 32: Medicaid Managed Long-Term Care 2023 Member Satisfaction Survey Data Collection Summary 96

Table 33: Medicaid Managed Long-Term Care 2021-2023 Member Satisfaction Results 97

Table 34: Managed Care Plan Response to Recommendation Assessment Levels..... 98

Table 35: AgeWell’s Performance Improvement Project Summary, 2023 102

Table 36: AgeWell’s Performance Improvement Project Indicator Summary, Measurement Years 2021 – 2023 103

Table 37: AgeWell Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 104

Table 38: AgeWell Medicaid Advantage Plus Network Gaps, Quarter 4 2023..... 105

Table 39: AgeWell’s Strengths, Opportunities, and Recommendations..... 105

Table 40: Centers Plan’s Response to the 2022 External Quality Review Recommendations 107

Table 41: Centers Plan’s Performance Improvement Project Summary, 2023..... 109

Table 42: Centers Plan’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 109

Table 43: Centers Plan Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 110

Table 44: Centers Plan Medicaid Advantage Plus Network Gaps, Quarter 4 2023 110

Table 45: Centers Plan’s Member Satisfaction Results, Measurement Years 2021 to 2023 111

Table 46: Centers Plan’s Strengths, Opportunities, and Recommendations..... 111

Table 47: Elderplan’s Response to the 2022 External Quality Review Recommendations 114

Table 48: Elderplan’s Performance Improvement Project Summary, 2023 116

Table 49: Elderplan’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 117

Table 50: Elderplan Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 118

Table 51: Elderplan Medicaid Advantage Plus Network Gaps, Quarter 4 2023..... 119

Table 52: Elderplan’s Member Satisfaction Results, Measurement Years 2021 to 2023 119

Table 53: Elderplan’s Strengths, Opportunities, and Recommendations..... 120

Table 54: Empire BCBS HealthPlus’s Response to 2022 External Quality Review Recommendations 123

Table 55: Empire BCBS HealthPlus’s Performance Improvement Project Summary, 2023 124

Table 56: Empire BCBS HealthPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 125

Table 57: Empire BCBS HealthPlus Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 126

Table 58: Empire BCBS HealthPlus Medicaid Advantage Plus Network Gaps, Quarter 4 2023 127

Table 59: Empire BCBS HealthPlus’s Strengths, Opportunities, and Recommendations 127

Table 60: Fidelis’s Response to the 2022 External Quality Review Recommendations 130

Table 61: Fidelis Care’s Performance Improvement Project Summary, 2023 131

Table 62: Fidelis Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 132

Table 63: Fidelis Care Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 133

Table 64: Fidelis Care Medicaid Advantage Plus Network Gaps, Quarter 4 2023 134

Table 65: Fidelis Care’s Member Satisfaction Results, Measurement Years 2021 to 2023 135

Table 66: Fidelis Care’s Strengths, Opportunities, and Recommendations 135

Table 67: Hamaspik’s Response to the 2022 External Quality Review Recommendations 138

Table 68: Hamaspik’s Performance Improvement Project Summary, 2023 140

Table 69: Hamaspik’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 141

Table 70: Hamaspik Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 142

Table 71: Hamaspik Medicaid Advantage Plus Network Gaps, Quarter 4 2023 143

Table 72: Hamaspik’s Member Satisfaction Results, Measurement Years 2021 to 2023 143

Table 73: Hamaspik’s Strengths, Opportunities, and Recommendations 144

Table 74: MetroPlus’s Response to 2022 External Quality Review Recommendations 147

Table 75: MetroPlus’s Performance Improvement Project Summary, 2023 149

Table 76: MetroPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 150

Table 77: MetroPlus Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 151

Table 78: MetroPlus Medicaid Advantage Plus Network Gaps, Quarter 4 2023 152

Table 79: MetroPlus’s Strengths, Opportunities, and Recommendations 152

Table 80: MHI Healthfirst’s Response to the 2022 External Quality Review Recommendations 155

Table 81: MHI Healthfirst’s Performance Improvement Project Summary, 2023 157

Table 82: MHI Healthfirst’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 158

Table 83: MHI Healthfirst Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 159

Table 84: MHI Healthfirst Medicaid Advantage Plus Network Gaps, Quarter 4 2023..... 160

Table 85: MHI Healthfirst’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 160

Table 86: MHI Healthfirst’s Strengths, Opportunities, and Recommendations 161

Table 87: Riverspring’s Response to the 2022 External Quality Review Recommendations 164

Table 88: RiverSpring’s Performance Improvement Project Summary, 2023 165

Table 89: RiverSpring’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 166

Table 90: RiverSpring Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 167

Table 91: RiverSpring Medicaid Advantage Plus Network Gaps, Quarter 4 2023 168

Table 92: RiverSpring’s Strengths, Opportunities, and Recommendations 168

Table 93: Senior Whole Health’s Response to the 2022 External Quality Review Recommendations 171

Table 94: Senior Whole Health's Performance Improvement Project Summary, 2023 172

Table 95: Senior Whole Health's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021- 2023 173

Table 96: Senior Whole Health Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 174

Table 97: Senior Whole Health Medicaid Advantage Plus Network Gaps, Quarter 4 2023 175

Table 98: Senior Whole Health’s Strengths, Opportunities, and Recommendations..... 175

Table 99: VillageCare’s Response to the 2022 External Quality Review Recommendations..... 178

Table 100: VillageCare’s Performance Improvement Project Summary, 2023..... 179

Table 101: VillageCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 180

Table 102: VillageCare Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 181

Table 103: VillageCare Medicaid Advantage Plus Network Gaps, Quarter 4 2023 181

Table 104: VillageCare’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 182

Table 105: VillageCare’s Strengths, Opportunities, and Recommendations 182

Table 106: VNS Health’s Response to the 2022 External Quality Review Recommendations 185

Table 107: VNS Health’s Performance Improvement Project Summary, 2023 186

Table 108: VNS Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 187

Table 109: VNS Health Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023 188

Table 110: VNS Health Medicaid Advantage Plus Network Gaps, Quarter 4 2023 189

Table 111: VNS Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 190

Table 112: VNS Health’s Strengths, Opportunities, and Recommendations..... 190

Table 113: Aetna’s Response to 2022 External Quality Review Recommendations 194

Table 114: Aetna’s Managed Long-Term Care Plan Performance Improvement Project Summary, 2023 195

Table 115: Aetna’s Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021- 2023 196

Table 116: Aetna Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 197

Table 117: Aetna’s Compliance with Federal Medicaid Standards Findings 197

Table 118: Aetna’s Compliance Review Summary of Results, 2023..... 198

Table 119: Aetna Partial Capitation Network Gaps, Quarter 4 2023 198

Table 120: Aetna’s Member Satisfaction Results, Measurement Years 2021 to 2023 199

Table 121: Aetna’s Strengths, Opportunities, and Recommendations 199

Table 122: ArchCare’s Response to 2022 External Quality Review Recommendations 202

Table 123: ArchCare’s Managed Long-Term Care Plan Performance Improvement Project Summary, 2023 203

Table 124: ArchCare’s Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021- 2023 204

Table 125: ArchCare Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 205

Table 126: ArchCare’s Compliance with Federal Medicaid Standards Findings 205

Table 127: ArchCare’s Compliance Review Summary of Results, 2023 206

Table 128: ArchCare Partial Capitation Network Gaps, Quarter 4 2023 206

Table 129: ArchCare’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 207

Table 130: ArchCare’s Strengths, Opportunities, and Recommendations 207

Table 131: Center Plan’s Response to 2022 External Quality Review Recommendations 210

Table 132: Centers Plan’s Managed Long-Term Care Plan Performance Improvement Project Summary, 2023. 211

Table 133: Centers Plan’s Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021- 2023 212

Table 134: Centers Plan Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023.. 213

Table 135: Centers Plan’s Compliance with Federal Medicaid Standards Findings..... 214

Table 136: Centers Plan’s Compliance Review Summary of Results, 2023 214

Table 137: Centers Plan Partial Capitation Network Gaps, Quarter 4 2023..... 215

Table 138: Centers Plan’s Member Satisfaction Results, Measurement Years 2021 to 2023 215

Table 139: Centers Plan’s Strengths, Opportunities, and Recommendations..... 216

Table 140: Elderplan’s Response to 2022 External Quality Review Recommendations..... 219

Table 141: Elderplan’s Performance Improvement Project Summary, 2023 221

Table 142: Elderplan’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 222

Table 143: Elderplan Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023..... 223

Table 144: Elderplan’s Compliance with Federal Medicaid Standards Findings 224

Table 145: Elderplan’s Compliance Review Summary of Results, 2023 225

Table 146: Elderplan Partial Capitation Network Gaps, Quarter 4 2023..... 226

Table 147: Elderplan’s Member Satisfaction Results, Measurement Years 2021 to 2023 226

Table 148: Elderplan’s Strengths, Opportunities, and Recommendations..... 227

Table 149: Elderwood’s Performance Improvement Project Summary, 2023 229

Table 150: Elderwood’s Performance Improvement Project Summary, Measurement Years 2021-2023 230

Table 151: Elderwood Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 231

Table 152: Elderwood’s Compliance with Federal Medicaid Standards Findings 231

Table 153: Elderwood’s Compliance Review Summary of Results, 2023 232

Table 154: Elderwood Partial Capitation Network Gaps, Quarter 4 2023 234

Table 155: Elderwood’s Member Satisfaction Results, Measurement Years 2021 to 2023 234

Table 156: Elderwood’s Strengths, Opportunities, and Recommendations 235

Table 157: Empire BCBS HealthPlus’s Response to 2022 External Quality Review Recommendations 237

Table 158: Empire BCBS HealthPlus’s Performance Improvement Project Summary, 2023 238

Table 159: Empire BCBS HealthPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 239

Table 160: Empire BCBS HealthPlus Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 240

Table 161: Empire BCBS HealthPlus Compliance with Federal Standards Results 240

Table 162: Empire BCBS HealthPlus’s Member Satisfaction Results, Measurement Years 2021 to 2023 241

Table 163: Empire BCBS HealthPlus’s Strengths, Opportunities, and Recommendations 242

Table 164: EverCare’s Performance Improvement Project Summary, 2023 245

Table 165: EverCare Choice’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 246

Table 166: EverCare Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023..... 247

Table 167: EverCare’s Compliance with Federal Standards Results 247

Table 168: EverCare’s Compliance Review Summary of Results, 2023 248

Table 169: Evercare Partial Capitation Network Gaps, Quarter 4 2023 248

Table 170: EverCare’s Member Satisfaction Results, Measurement Years 2021 to 2023 249

Table 171: EverCare’s Strengths, Opportunities, and Recommendations 249

Table 172: Extended MLTC’s Performance Improvement Project Summary, 2022..... 252

Table 173: Extended MLTC’s Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022 253

Table 174: Extended MLTC Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 254

Table 175: Extended MLTC’s Compliance with Federal Standards Results 255

Table 176: Extended MLTC’s Compliance Review Summary of Results, 2023 255

Table 177: Extended MLTC’s Member Satisfaction Results, Measurement Years 2021 to 2023 256

Table 178: Extended MLTC’s Strengths, Opportunities, and Recommendations 256

Table 179: Fallon Health’s Performance Improvement Project Summary, 2023..... 258

Table 180: Fallon Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021 – 2023 258

Table 181: Fallon Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023. 259

Table 182: Fallon Health’s Compliance with Federal Medicaid Standards Findings..... 260

Table 183: Fallon Health Partial Capitation Network Gaps, Quarter 4 2023..... 260

Table 184: Fallon Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 261

Table 185: Fallon Health’s Strengths, Opportunities, and Recommendations..... 262

Table 186: Fidelis Care’s Response to 2022 External Quality Review Recommendations 264

Table 187: Fidelis Care’s Performance Improvement Project Summary, 2023 265

Table 188: Fidelis Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 266

Table 189: Fidelis Care Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 ... 267

Table 190: Fidelis Care’s Compliance with Federal Medicaid Standards Findings 267

Table 191: Fidelis Care’s Compliance Review Summary of Results, 2023 268

Table 192: Fidelis Care Partial Capitation Network Gaps, Quarter 4 2023 268

Table 193: Fidelis Care’s Member Satisfaction Results, Measurement Years 2021 to 2023 269

Table 194: Fidelis Care’s Strengths, Opportunities, and Recommendations 269

Table 195: Hamaspik’s Response to 2022 External Quality Review Recommendations 272

Table 196: Hamaspik’s Performance Improvement Project Summary, 2023..... 273

Table 197: Hamaspik’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 274

Table 198: Hamaspik Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 275

Table 199: Hamaspik’s Compliance with Federal Medicaid Standards Findings 276

Table 200: Hamaspik’s Compliance Review Summary of Results, 2023 276

Table 201: Hamaspik Partial Capitation Network Gaps, Quarter 4 2023 277

Table 202: Hamaspik’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 277

Table 203: Hamaspik’s Strengths, Opportunities, and Recommendations 278

Table 204: iCircle’s Response to 2022 External Quality Review Recommendations 281

Table 205: iCircle’s Performance Improvement Project Summary, 2023 283

Table 206: iCircle’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 .. 284

Table 207: iCircle Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 285

Table 208: iCircle’s Compliance with Federal Medicaid Standards Findings..... 285

Table 209: iCircle’s Compliance Review Summary of Results, 2023 286

Table 210: iCircle Partial Capitation Network Gaps, Quarter 4 2023 286

Table 211: iCircle’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 287

Table 212: iCircle’s Strengths, Opportunities, and Recommendations 287

Table 213: Kalos Health’s Response to 2022 External Quality Review Recommendations 290

Table 214: Kalos Health’s Performance Improvement Project Summary, 2023..... 291

Table 215: Kalos Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 292

Table 216: Kalos Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 .. 293

Table 217: Kalos Health’s Compliance with Federal Medicaid Standards Findings..... 293

Table 218: Kalos Health’s Compliance Review Summary of Results, 2023 294

Table 219: Kalos Partial Capitation Network Gaps, Quarter 4 2023 294

Table 220: Kalos Health’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 295

Table 221: Kalos Health’s Strengths, Opportunities, and Recommendations 295

Table 222: MetroPlus’s Response to 2022 External Quality Review Recommendations 298

Table 223: MetroPlus’s Performance Improvement Project Summary, 2023 299

Table 224: MetroPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 300

Table 225: MetroPlus Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 301

Table 226: MetroPlus’s Compliance with Federal Medicaid Standards Findings 301

Table 227: MetroPlus’s Compliance Review Summary of Results, 2023..... 302

Table 228: MetroPlus Partial Capitation Network Gaps, Quarter 4 2023 303

Table 229: MetroPlus’s Member Satisfaction Results, Measurement Years 2021 to 2023 303

Table 230: MetroPlus’s Strengths, Opportunities, and Recommendations 304

Table 231: Montefiore’s Performance Improvement Project Summary, 2023 307

Table 232: Montefiore’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 308

Table 233: Montefiore Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023.... 309

Table 234: Montefiore’s Compliance with Federal Medicaid Standards Findings 309

Table 235: Montefiore’s Compliance Review Summary of Results, 2023 310

Table 236: Montefiore Partial Capitation Network Gaps, Quarter 4 2023..... 311

Table 237: Montefiore’s Member Satisfaction Results, Measurement Years 2021 to 2023 311

Table 238: Montefiore’s Strengths, Opportunities, and Recommendations..... 312

Table 239: Nascentia’s Response to 2022 External Quality Review Recommendations 314

Table 240: Nascentia’s Performance Improvement Project Summary, 2023..... 316

Table 241: Nascentia’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 316

Table 242: Nascentia Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 317

Table 243: Nascentia’s Compliance with Federal Medicaid Standards Findings..... 317

Table 244: Nascentia’s Compliance Review Summary of Results, 2023 318

Table 245: Nascentia Partial Capitation Network Gaps, Quarter 4 2023 318

Table 246: Nascentia’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 319

Table 247: Nascentia’s Strengths, Opportunities, and Recommendations 320

Table 248: Prime Health's Performance Improvement Project Summary, 2023..... 323

Table 249: Prime Health's Performance Improvement Project Indicator Summary, Measurement Years 2021-2023 324

Table 250: Prime Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023. 325

Table 251: Prime Health’s Compliance with Federal Medicaid Standards Findings..... 325

Table 252: Prime Health’s Compliance Review Summary of Results, 2023 326

Table 253: Prime Health Partial Capitation Network Gaps, Quarter 4 2023 327

Table 254: Prime Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 328

Table 255: Prime Health’s Strengths, Opportunities, and Recommendations..... 329

Table 256: RiverSpring’s Response to 2022 External Quality Review Recommendations 332

Table 257: RiverSpring’s Performance Improvement Project Summary, 2023 334

Table 258: RiverSpring’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 334

Table 259: RiverSpring Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023.... 335

Table 260: RiverSpring’s Compliance with Federal Medicaid Standards Findings 336

Table 261: RiverSpring’s Compliance Review Summary of Results, 2023 336

Table 262: Riverspring Partial Capitation Network Gaps, Quarter 4 2023..... 337

Table 263: RiverSpring’s Member Satisfaction Results, Measurement Years 2021 to 2023 337

Table 264: RiverSpring’s Strengths, Opportunities, and Recommendations 338

Table 265: Senior Health Partners’ Response to 2022 External Quality Review Recommendations 341

Table 266: Senior Health Partners Performance Improvement Project Summary, 2023 342

Table 267: Senior Health Partners’ Performance Improvement Project Indicator Summary, Measurement Years 2021 – 2023 343

Table 268: Senior Health Partners’ Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 344

Table 269: Senior Health Partners’ Compliance with Federal Medicaid Standards Findings..... 344

Table 270: Senior Health Partners’ Compliance Review Summary of Results, 2023 345

Table 271: Senior Health Partners’ Partial Capitation Network Gaps, Quarter 4 2023..... 345

Table 272: Senior Health Partners’ Member Satisfaction Results, Measurement Years 2021 to 2023..... 346

Table 273: Senior Health Partners’ Strengths, Opportunities, and Recommendations 347

Table 274: Senior Network Health's Performance Improvement Project Summary, 2023 350

Table 275: Senior Network Health's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 351

Table 276: Senior Network Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 352

Table 277: Senior Network Health’s Compliance with Federal Medicaid Standards Findings 352

Table 278: Senior Network Health’s Compliance Review Summary of Results, 2023..... 353

Table 279: Senior Network Health Partial Capitation Network Gaps, Quarter 4 2023 353

Table 280: Senior Network Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 354

Table 281: Senior Network Health’s Strengths, Opportunities, and Recommendations 354

Table 282: Senior Whole Health’s Response to 2022 External Quality Review Recommendations..... 357

Table 283: Senior Whole Health's Performance Improvement Project Summary, 2023 358

Table 284: Senior Whole Health's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 359

Table 285: Senior Whole Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 360

Table 286: Senior Whole Health’s Compliance with Federal Medicaid Standards Findings 360

Table 287: Senior Whole Health’s Compliance Review Summary of Results, 2023 361

Table 288: Senior Whole Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 361

Table 289: Senior Whole Health’s Strengths, Opportunities, and Recommendations..... 362

Table 290: VillageCare’s Response to 2022 External Quality Review Recommendations 365

Table 291: VillageCare’s Performance Improvement Project Summary, 2023..... 367

Table 292: VillageCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 368

Table 293: VillageCare Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023 369

Table 294: VillageCare’s Compliance with Federal Medicaid Standards Findings..... 369

Table 295: VillageCare’s Compliance Review Summary of Results, 2023 370

Table 296: VillageCare’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 371

Table 297: VillageCare’s Strengths, Opportunities, and Recommendations 371

Table 298: VNS Health’s Response to 2022 External Quality Review Recommendations..... 374

Table 299: VNS Health’s Performance Improvement Project Summary, 2023 376

Table 300: VNS Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 377

Table 301: VNS Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023.... 378

Table 302: VNS Health’s Compliance with Federal Medicaid Standards Findings 378

Table 303: VNS Health’s Compliance Review Summary of Results, 2023 379

Table 304: VNS Health Partial Capitation Network Gaps, Quarter 4 2023..... 379

Table 305: VNS Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 381

Table 306: VNS Health’s Strengths, Opportunities, and Recommendations..... 381

Table 307: ArchCare’s Response to 2022 External Quality Review Recommendations 385

Table 308: ArchCare’s Performance Improvement Project Summary, 2023 387

Table 309: ArchCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 387

Table 310: ArchCare Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 388

Table 311: ArchCare’s Compliance with Federal Medicaid Standards Findings 388

Table 312: ArchCare’s Compliance Review Summary of Results, 2023 389

Table 313: ArchCare Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023 389

Table 314: ArchCare’s Member Satisfaction Results, Measurement Years 2021 to 2023..... 390

Table 315: ArchCare’s Strengths, Opportunities, and Recommendations 390

Table 316: Catholic Health’s Response to 2022 External Quality Review Recommendations 393

Table 317: Catholic Health’s Managed Long-Term Care Plan Performance Improvement Project Summary, 2023 395

Table 318: Catholic Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 396

Table 319: Catholic Health Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 397

Table 320: Catholic Health’s Compliance with Federal Medicaid Standards Findings 398

Table 321: Catholic Health’s Compliance Review Summary of Results, 2023..... 398

Table 322: Catholic Health’s Member Satisfaction Results, Measurement Years 2021 to 2023 399

Table 323: Catholic Health’s Strengths, Opportunities, and Recommendations 400

Table 324: CenterLight’s Response to 2022 External Quality Review Recommendations 402

Table 325: CenterLight’s Performance Improvement Project Summary, 2023 404

Table 326: CenterLight’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 405

Table 327: CenterLight Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 406

Table 328: CenterLight’s Compliance with Federal Medicaid Standards Findings 406

Table 329: CenterLight’s Compliance Review Summary of Results, 2023 407

Table 330: CenterLight Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023 407

Table 331: CenterLight’s Member Satisfaction Results, Measurement Years 2021 to 2023 408

Table 332: CenterLight’s Strengths, Opportunities, and Recommendations 408

Table 333: Complete Senior Care’s Response to 2022 External Quality Review Recommendations 411

Table 334: Complete Senior Care’s Performance Improvement Project Summary, 2023 412

Table 335: Complete Senior Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 413

Table 336: Complete Senior Care Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 414

Table 337: Complete Senior Care’s Compliance with Federal Medicaid Standards Findings 414

Table 338: Complete Senior Care’s Compliance Review Summary of Results, 2023 415

Table 339: Complete Senior Care Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023 415

Table 340: Complete Senior Care’s Member Satisfaction Results, Measurement Years 2021 to 2023 416

Table 341: Complete Senior Care’s Strengths, Opportunities, and Recommendations 417

Table 342: Eddy SeniorCare’s Response to 2022 External Quality Review Recommendations 420

Table 343: Eddy SeniorCare’s Performance Improvement Project Summary, 2023 421

Table 344: Eddy SeniorCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 422

Table 345: Eddy SeniorCare Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 423

Table 346: Eddy Senior Care’s Compliance with Federal Medicaid Standards Findings 423

Table 347: Eddy Senior Care’s Compliance Review Summary of Results, 2023 424

Table 348: Eddy Senior Care Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023 424

Table 349: Eddy SeniorCare’s Member Satisfaction Results, Measurement Years 2021 to 2023 425

Table 350: Eddy Senior Care’s Strengths, Opportunities, and Recommendations 426

Table 351: ElderONE’s Response to 2022 External Quality Review Recommendations 429

Table 352: ElderONE’s Performance Improvement Project Summary, 2023 430

Table 353: ElderONE’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 431

Table 354: ElderONE Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 432

Table 355: ElderONE’s Compliance with Federal Medicaid Standards Findings 432

Table 356: ElderONE’s Compliance Review Summary of Results, 2023..... 433

Table 357: ElderONE Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023 433

Table 358: ElderONE’s Member Satisfaction Results, Measurement Years 2021 to 2023 434

Table 359: ElderONE’s Strengths, Opportunities, and Recommendations 434

Table 360: Fallon Health’s Performance Improvement Project Summary, 2023..... 439

Table 361: Fallon Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023 439

Table 362: Fallon Health Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 440

Table 363: Fallon Health’s Compliance with Federal Medicaid Standards Findings..... 440

Table 364: Fallon Health’s Compliance Review Summary of Results, 2023 441

Table 365: Fallon Health Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023 442

Table 366: Fallon Health’s Strengths, Opportunities, and Recommendations..... 443

Table 367: PACE CNY Performance Improvement Project Summary, 2023 448

Table 368: PACE CNY’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023 448

Table 369: PACE CNY Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 449

Table 370: PACE CNY’s Member Satisfaction Results, Measurement Years 2021 to 2023 450

Table 371: PACE CNY’s Strengths, Opportunities, and Recommendations 451

Table 372: Total Senior Care’s Response to 2022 External Quality Review Recommendations..... 453

Table 373: Total Senior Care’s Performance Improvement Project Summary, 2023..... 454

Table 374: Total Senior Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023 455

Table 375: Total Senior Care Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023 456

Table 376: Total Senior Care’s Compliance with Federal Medicaid Standards Findings..... 456

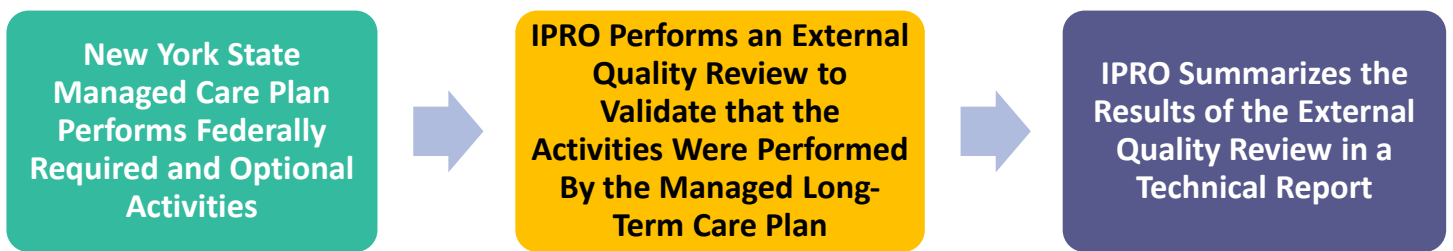
Table 377: Total Senior Care’s Compliance Review Summary of Results, 2023 457

Table 378: Total Senior Care Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023..... 457

Table 379: Total Senior Care’s Strengths, Opportunities, and Recommendations..... 458

About This Report

The Balanced Budget Act of 1997 requires that state agencies contracting with Medicaid managed care and Children's Health Insurance Program plans provide for an annual, external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. The New York State Department of Health contracted with IPRO, an external quality review organization, to conduct the 2023 external quality review of the managed care plans that comprised New York's Medicaid managed care and Child Health Plus programs. Review results for one of New York's Medicaid products (Managed Long-Term Care) are summarized in this report, while results of New York's three other Medicaid products (Mainstream Medicaid, HIV Special Needs Plan, and Health and Recovery Plan) and Child Health Plus programs are summarized in a separate report.



This external quality review technical report focuses on four federally required activities (performance improvement projects, performance measures, review of compliance with Medicaid and Children's Health Insurance Program standards, and validation of network adequacy), as well as one optional activity (administration of quality of care surveys) that were conducted between January 1, 2023, and December 31, 2023, or measurement year 2023.

Table 1: Managed Long-Term Care External Quality Review Activities Performed for 2023

What Did the Department of Health Do?	What Did the Managed Long-Term Care Plans Do?	What Did IPRO Do?
Required all managed care plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects.	Conducted performance improvement projects on social determinants of health screenings and follow-up.	Evaluated how the managed care plans conducted performance improvement projects.
Required all managed care plans to collect and report certain health data. These data are called performance measures.	Conducted Community Health Assessments of their members.	Validated the data collected through the Community Health Assessment.
Required all managed care plans to comply with federal and state standards for Medicaid; and conducted an evaluation to determine managed care plan compliance with these standards.	Presented evidence of compliance with Medicaid standards to the Department of Health.	Reviewed the results of an evaluation of managed care plan compliance with Medicaid standards.

What Did the Department of Health Do?	What Did the Managed Long-Term Care Plans Do?	What Did IPRO Do?
Required all managed care plans to comply with network adequacy standards and conducted an evaluation to determine managed care compliance with these standards.	Collected and reported network adequacy data to the Department of Health.	Reviewed the results of an evaluation of managed care plan network adequacy.
Sponsored a quality-of-care survey, conducted by IPRO, for all Managed Long-Term Care plans.	Used these findings in planning future activities to address or enhance member experience.	Conducted a survey on member experience with Managed Long-Term Care plans.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care and Children's Health Insurance Program plans provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. The Medicaid standards at *Title 42 Code of Federal Regulations Section 438.350 External quality review* and Child Health Insurance Program standards at *Title 42 Code of Federal Regulations Section 457.1250 External quality review* set forth the requirements for the annual external quality review of contracted managed care plans¹. (*Hereafter, only Medicaid standards are referenced.*) States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care and Children's Health Insurance Program plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare & Medicaid Services.² Quality, as it pertains to an external quality review, is defined in *Title 42 Code of Federal Regulations 438.320 Definitions* as “the degree to which a managed care plan, PIHP³, PAHP⁴, or PCCM⁵ entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement.”

Title 42 Code of Federal Regulations 438.364 External quality review results (a) through (d) requires that the annual external quality review be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that managed care plans furnish to Medicaid and Children’s Health Insurance Program recipients. The report must also contain an assessment of the strengths and weaknesses of the managed care plans with respect to health care quality, timeliness, and access, as well as recommendations for improvement.

¹ Child Health Insurance Program standards at *Title 42 Code of Federal Regulations 457.1250* cross-reference to the Medicaid managed care external quality review requirements at *Title 42 Code of Federal Regulations 438.356*.

² The Centers for Medicare & Medicaid Services website: <https://www.cms.gov/>.

³ prepaid inpatient health plan.

⁴ prepaid ambulatory health plan.

⁵ primary care case management.

To comply with *Title 42 Code of Federal Regulations Section 438.364 External quality review results (a) through (d)* and *Title 42 Code of Federal Regulations 438.358 Activities related to external quality review*, the Department of Health has contracted with IPRO, an external quality review organization, to conduct the 2023 external quality review of the managed care plans that are part of New York’s Managed Long-Term Care program.

2023 External Quality Review

This external quality review technical report focuses on four federally required activities (validation of performance improvement projects, validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy), as well as one optional activity (administration of quality of care surveys) that were conducted for measurement year 2023. IPRO’s external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*⁶ published in February 2023. The external quality review activities and corresponding protocols are described in **Table 2**.

Table 2: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed managed care plan performance improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Department of Health’s methodology for calculating performance rates using data reported to the Uniform Assessment System for New York by New York’s Independent Assessor Program and Managed Long-Term Care plans. The Uniform Assessment System for New York includes the Community Health Assessment which is a web-based tool to conduct assessments at enrollment and annually thereafter, or sooner if needed.
Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of evaluations performed by the Department of Health and the Centers for Medicare & Medicaid Services of Managed Long-Term Care plan compliance with Medicaid standards. Specifically, this review assessed compliance with the Medicaid Advantage Plus model contract, Managed Long-Term Care Partial Capitation contract, and Programs of All-Inclusive Care for the Elderly Managed Long-Term Care contract.

⁶ The Centers for Medicare & Medicaid Services External Quality Review Protocols website: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf> .

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 4. Validation of Network Adequacy (Required)	Protocol 4	IPRO reviewed the results of the Department of Health’s analyses of managed care plan provider network data to determine managed care plan compliance with state network adequacy standards.
Activity 6. Administration of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO administered a survey, on behalf of the Department of Health, to evaluate member experience with New York’s Medicaid Managed Long-Term Care program, managed care plans, and providers.

The results of IPRO’s external quality review are reported under each activity section.

New York State's Managed Care Programs and Quality Strategy for Medicaid and Child Health Plus

History of New York State's Managed Care Programs

The New York State Medicaid managed care program began in 1997 when New York State received approval from the Centers for Medicare & Medicaid Services to mandatorily enroll Medicaid members in a managed care program through a Section 1115 Demonstration Waiver.⁷ Section 1115 of the Social Security Act allows for “demonstration projects” to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The New York State Section 1115 Demonstration Waiver project had these goals in 2023:

- Increasing access to health care for the Medicaid population.
- Improving the quality of health care services delivered.
- Expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

New York State's Medicaid managed care program offers a variety of managed care plans to coordinate the provision, quality, and payment of care for its enrolled members. Medicaid members not in need of specialized services are enrolled into health maintenance organizations or prepaid health services plans (referred to as “Mainstream Medicaid”). Members with specialized health care needs can opt to join available specialized managed care plans. Current specialized Medicaid plans include HIV Special Needs Plans, Health and Recovery Plans, and Managed Long-Term Care plans.

New York's Title XXI program, Child Health Plus is a “combination program” comprising both a Medicaid expansion and a separate state program. The program began as a state-funded initiative in 1990, to provide preventive, primary, and outpatient care to children. In 1997, with the passage of the Balanced Budget Act and the creation of the State Children's Health Insurance Program, New York's program was “grandfathered” into Title XXI.

Today, Child Health Plus offers free or low-cost health insurance to uninsured children from birth until the end of the month of their 19th birthday. To qualify, families must have incomes below 400% of the federal poverty level, and the child(ren) must be a resident of New York State, be ineligible for Medicaid, must not be enrolled in other health insurance or have access to a State Health Benefits plan. There are no deductibles, co-payments, or co-insurance, but families with incomes above 222% federal poverty level are required to pay a monthly premium. All Child Health Plus health services in New York State are provided through managed care plans. Application and renewal for Child Health Plus is through NY State of Health, The Official Health Plan Marketplace, where consumers are able to apply for and renew Child Health Plus coverage, as well as enroll in a health plan.

New York State's Medicaid and Child Health Plus Quality Strategy

New York maintains rigorous standards to ensure that approved health plans have networks and quality management programs necessary to serve all enrolled populations. The quality strategy developed by the Department of Health is intended to be the quality framework for New York State's Medicaid and Child Health Plus programs and participating managed care plans. The Department of Health performs periodic reviews of its Medicaid and Child Health Plus quality strategy to determine the need for revision and to ensure managed care

⁷ Medicaid.gov About 1115 Demonstrations Website: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> .

plans are compliant with regulatory standards and have committed adequate resources to perform internal monitoring and ongoing quality improvement. The Department of Health updates the Medicaid and Child Health Plus quality strategy as needed, but no less than once every three years.

New York State’s January 2023-December 2025 Medicaid and Child Health Plus Program Quality Strategy⁸ focuses on identifying objectives for the quality of the Medicaid and Child Health Plus programs, which advance overarching goals; tracking progress on at least one metric per objective; and identifying, evaluating, and reducing extant health disparities within each metric. New York State’s Medicaid and Child Health Plus quality strategy’s eight overarching goals are displayed in Error! Reference source not found..

Table 3: New York State’s Medicaid and Child Health Plus Quality Strategy Goals

<p>Goal 1. Prevent and Manage Chronic Diseases</p>	<p>Goal 2. Promote Healthy and Safe Environments, Supporting Members in Their Communities</p>	<p>Goal 3. Promote Healthy Women, Infants, and Children</p>	<p>Goal 4. Promote Wellbeing and Prevent and Manage Mental Health and Substance Use Disorders</p>
<p>Goal 5. Prevent and Manage Communicable Diseases</p>	<p>Goal 6. Improve Systems and Infrastructure</p>	<p>Goal 7. Increase Access to Care</p>	<p>Goal 8. Promote High Quality Outpatient Care</p>

The state has further identified 21 objectives and 33 metrics to track progress towards the eight goals above. These metrics were selected from the New York State Quality Assurance Reporting Requirements measurement set, the Centers for Disease Control and Prevention’s American Community Survey, 3M’s Potentially Preventable Admissions, and other New York State-specific measures. **Table 4** presents linkages of the eight goals to their corresponding objectives, and **Table 5** presents a summary of the state’s quality strategy measurement plan, including objectives, metric names, populations included in the calculation of the metrics, baseline data, and targets. Unless indicated otherwise, baseline measurements are from measurement year 2021 (January 1, 2021 through December 31, 2021).

⁸ The New York State Medicaid and Child Health Plus Program Quality Strategy website: https://www.health.ny.gov/health_care/medicaid/data_rpts/docs/2024-09-05_chplus_quality_strategy_final.pdf.

Table 4: New York State’s Medicaid and Child Health Plus Quality Strategy Goals and Objectives, January 2023-December 2025

Objectives	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8
	Prevent and Manage Chronic Diseases	Promote Healthy and Safe Environments, Supporting Members in Their Communities	Promote Healthy Women, Infants, and Children	Promote Wellbeing and Prevent and Manage Mental Health and Substance Use Disorders	Prevent and Manage Communicable Diseases	Improve Systems and Infrastructure	Increase Access to Care	Promote High Quality Outpatient Care
1. Support and advance an equitable Medicaid and Child Health Plus program	X	X	X	X	X	X	X	
2. Promote a system that facilitates consistent access to care	X	X	X	X		X	X	
3. Ensure coordinated care and promote integrated care	X	X	X	X				
4. Support members in their communities		X						
5. Promote community based organization partnerships	X	X	X	X	X	X	X	
6. Improve the health and safety of members’ environments	X	X	X	X	X	X		
7. Promote a sustainable provider workforce and capacity						X	X	X
8. Ensure and incentivize high quality care						X		X
9. Improve access to and quality of behavioral healthcare	X		X	X	X		X	X
10. Improve access to and quality of dental care	X		X				X	X
11. Improve access to and quality of maternal healthcare	X		X	X	X	X	X	X
12. Improve access to and quality of Home and Community Based	X	X	X		X	X	X	X

Objectives	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8
	Prevent and Manage Chronic Diseases	Promote Healthy and Safe Environments, Supporting Members in Their Communities	Promote Healthy Women, Infants, and Children	Promote Wellbeing and Prevent and Manage Mental Health and Substance Use Disorders	Prevent and Manage Communicable Diseases	Improve Systems and Infrastructure	Increase Access to Care	Promote High Quality Outpatient Care
Services								
13. Improve access to and quality of patient-centered primary care	X	X	X	X			X	X
14. Improve access to and quality of care for infants and children	X	X	X	X	X	X	X	X
15. Improve access to and quality of chronic disease management	X	X	X				X	X
16. Increase utilization of preventive healthcare services	X		X					X
17. Prevent chronic disease	X	X	X		X			
18. Promote data-driven Medicaid oversight and health plan accountability	X					X		
19. Promote member safety	X	X	X		X		X	
20. Reduce unnecessary emergency room visits and hospitalizations	X	X		X			X	X
21. Ensure members are able to receive care in the least restrictive setting possible		X						X

Table 5: New York State’s Medicaid and Child Health Plus Quality Strategy Metrics and Performance Rates

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Target by 2025
1. Support and advance an equitable Medicaid and Child Health Plus program	Reduce the number of uninsured ¹ (Statewide Population, ages 0 to 64 years)	2021	9%	8.2%	8%
2. Promote a system that facilitates consistent access to care	Adult CAHPS: Getting Care Quickly (Mainstream Medicaid and HIV Special Needs Plan, Health and Recovery Plan)	2021	79% ²	79% ²	85%
	Child CAHPS: Getting Care Quickly (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2020	88%	Non-Survey Year	91%
3. Ensure coordinated care and promote integrated care	Proportion of total population in Medicaid Advantage Plus, Program of All-Inclusive Care for the Elderly, and Partial in a Medicaid Advantage Plus or Program of All-Inclusive Care for the Elderly (Medicaid Managed Long-Term Care)	2022	14%	16%	15%
4. Support members in their communities	Quality of Home Health Aide/Personal Care Aide (Medicaid Managed Long-Term Care)	2021	91%	93%	95%
5. Promote community based organization partnerships	Social Need Screening and Intervention (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan)	2023	New Measure	First Year Rate Not Publicly Reported	20%
6. Improve the health and safety of members’ environments	No Falls Injury (Medicaid Managed Long-Term Care)	2022	90%	93%	91%
7. Promote a sustainable provider workforce and capacity	Medicaid Enrolled Dentists (New York State Licensed Dentists)	2022	42%	41%	46%
8. Ensure and incentivize high quality care	Proportion of Members in a Patient-Centered Medical Home (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan)	2022	66%	66%	67.5%
9. Improve access to and quality of behavioral healthcare	Follow-Up After Emergency Department Visit for Substance Use – 7 Day (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2022	32%	34%	33%

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Target by 2025
	Follow-Up After Emergency Department Visit for Substance Use – 30 Day (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2022	44%	45%	46%
	Follow-Up After Emergency Department Visit for Mental Illness - 7 Day (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	52%	Not to be Trended ³	54%
	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	67%	Not to be Trended ³	69%
10. Improve access to and quality of dental care	Topical Fluoride for Children (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2023	New Measure	First Year Rate Not Publicly Reported	To Be Determined
	Adult Annual Dental Visit (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan, Medicaid Fee-For-Service)	2021	20%	19%	22%
11. Improve access to and quality of maternal healthcare	Postpartum Care (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	81%	84%	82%
12. Improve access to and quality of Home and Community Based Services	Members in 1915c Programs with Physical Exam (Children’s Waiver Participants)	April 2021- March 2022	56% ⁴	80% ⁵	85% ⁶
13. Improve access to and quality of patient-centered primary care	Proportion of Members who Utilize Primary Care (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan, Managed Long-Term Care, Fee-For-Service)	2022	66%	63%	73%
14. Improve access to and quality of care for infants and children	Well-Child Visits in the First 30 Months of Life (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	72%	74%	73%

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Target by 2025
	Child and Adolescent Well-Care Visits (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	70%	70%	71%
	Follow-Up Care for Children Prescribed ADHD Medication – Initiation ⁷ (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	53%	56%	55%
	Follow-Up Care for Children Prescribed ADHD Medication – Continuation ⁷ (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	62%	62%	63%
15. Improve access to and quality of chronic disease management	Viral Load Suppression (Mainstream Medicaid Managed Care, Child Health Plus)	2021	73%	75%	75%
	Hemoglobin A1c Control for Patients with Diabetes – Glycemic Status Assessment for Patients With Diabetes (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan)	2021	55%	62%	57%
	Asthma Medication Ratio (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	55%	71%	56%
16. Increase utilization of preventive healthcare services	Colorectal Cancer Screening ⁸ (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan)	2021	61%	51%	62%
	Childhood Immunization Status - Combination 10 ⁸ (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	42%	34%	43%
17. Prevent chronic disease	Hepatitis C Elimination Measure – Universal Screening for Pregnant People (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan, Fee-For-Service)	2022	72%	69.5%	79%

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Target by 2025
18. Promote data-driven Medicaid oversight and health plan accountability	Completeness of Race/Ethnicity Data (Medicaid members (all ages) [managed care and Fee-For-Service])	2022	74%	79%	81%
19. Promote member safety	Pharmacotherapy for Opioid Use Disorder (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	32%	33%	33%
20. Reduce unnecessary emergency room visits and hospitalizations	Follow-Up After Hospitalization for Mental Illness – 7 Day (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	63%	63%	64%
	Follow-Up After Hospitalization for Mental Illness – 30 Day (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	79%	79%	80%
21. Ensure members are able to receive care in the least restrictive setting possible	Potentially Preventable Admissions Per 1,000 Members ¹ (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan, Fee-For-Service)	2021	8.86 per 1,000 members	7.94 per 1,000 members	7.97 per 1,000 members

¹ A lower rate indicates better performance.

² Only Mainstream Medicaid managed care results reported.

³ The New York State Department of Health identified inconsistencies in how HEDIS vendors classified certain visits for the *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* measure. As a result, the measure has been deemed unable to be trended for the 2023 measurement year. It will be re-evaluated in the future to assess its validity and its trending status.

⁴ This measure is calculated based on the state fiscal year (April-March). The Baseline Measurement Year rate is from April 2021-March 2022.

⁵ This measure is calculated based on the state fiscal year (April-March). The Measurement Year 2023 rate is from April 2022-March 2023.

⁶ This measure is calculated based on the state fiscal year (April-March). The Target Measurement Year 2025 rate is from April 2024-March 2025.

⁷ The Baseline Measurement Year rate was calculated using administrative methodology, and the Measurement Year 2023 rate was calculated using electronic methodology.

⁸ The Baseline Measurement Year rate was calculated using hybrid methodology, and the Measurement Year 2023 rate was calculated using electronic methodology.

To achieve the overall objectives of the New York State managed care programs and to ensure New York Medicaid and Child Health Plus recipients have access to the highest quality of health care, New York State’s January 2023-December 2025 Medicaid and Child Health Plus Program Quality Strategy focuses on measurement and assessment, improvement, redesign, contract compliance and oversight, and enforcement. The state targets improvement efforts through several activities such as clinical focus studies, clinical and non-clinical performance improvement projects, quality incentives, the quality performance matrix, performance reports, quality improvement conferences and trainings, and plan technical assistance. Descriptions of interventions planned by the Department of Health to achieve the goals of its January 2023-December 2025 Medicaid and Child Health Plus Program Quality Strategy are described below.

Objective 1. Support and Advance an Equitable Medicaid and Child Health Plus Program

- NY State of Health, The Official Health Plan Marketplace was developed to simplify health insurance enrollment and comparisons, and to help New Yorkers understand their eligibility for Medicaid or Child Health Plus.
- Through Child Health Plus, thousands of children who do not qualify for Medicaid have access to free or affordable health insurance.
- NY State of Health launched a significant marketing strategy, increased marketing to promote the enrollment website, created a text and email alert system for important health insurance updates and renewal reminders, held numerous stakeholder sessions to explain the public health emergency unwind and how New Yorkers can maintain health insurance, and conducted direct outreach via Navigators and Facilitated Enrollers.
- New York State uses the “ex parte” process to automate Medicaid and Child Health Plus renewals using existing data, estimating that about 40% of households enrolled through NY State of Health are renewed via ex parte.

Objective 2. Promote a System that Facilitates Consistent Access to Care

- NY State of Health heightened communication about renewals and free enrollment assistance to avoid gaps in coverage. Assistance is available in many languages and during non-traditional hours like evenings and weekends.
- The Medicaid Managed Care and Child Health Plus Model Contracts include various access requirements. Managed care plans must follow appointment availability standards and meet travel time standards. Provider network reports monitor compliance with access standards. The Department of Health conducts an annual survey, alternating between adult and child members, to monitor access to care.
- The New York State Patient-Centered Medical Home Program offers financial incentives to primary care providers who demonstrate patient-centered, high-quality practices. Patient access is a core competency, including evaluating appointment availability, operating beyond regular business hours, and using secure electronic systems for patient-provider communication.
- The Medicaid Transportation program ensures Medicaid members can get to and from medical appointments. It arranges non-emergency transportation, such as pre-scheduled trips to primary care and dental appointments, at no cost to the member. This benefit removes a barrier to care and accommodates each person’s medical mobility needs.

Objective 3. Ensure Coordinated Care and Promote Integrated Care

- The Department of Health’s Integrated Care Roadmap aims to 1) create more opportunities to build alignment between Medicare and Medicaid through integrated managed care plan offerings; 2) streamline managed care plan offerings and promote informed member choice; 3) enable fewer member transitions and build stronger continuity of care; and 4) simplify administrative infrastructure for providers and managed care

plans. To achieve these goals, there are several initiatives underway. When a member becomes Medicare-eligible, there is default enrollment in Medicaid Advantage Plus where appropriate.

- Increased marketing of integrated plans as well as alternative processes for Program of All-Inclusive Care for the Elderly plan enrollment are intended to increase Medicaid Advantage Plus and Program of All-Inclusive Care for the Elderly plan enrollment. The Department of Health also aims to promote integration of physical and behavioral healthcare, which is described in more detail in Objective 9.

Objective 4. Support Members in Their Communities

- The Department of Health brings care to members in their communities through various programs. The Consumer Directed Personal Assistance Program aids with daily living activities and skilled nursing services for individuals needing home care, empowering members with flexibility and autonomy in choosing caregivers and assistance types (not applicable to Child Health Plus).
- The Money Follows the Person Demonstration funds 24 Open Doors Transition Centers, helping individuals in institutional care transition back into the community by identifying needed supports, coordinating medical services, and offering peer support (not applicable to Child Health Plus)
- The New York State Medicaid and Child Health Plus Programs cover a range of telehealth services, facilitating care at home or convenient locations. New York implemented payment parity for telehealth services under State Law Chapter 45 Article 29-G §2999-DD.
- New York State currently covers community health worker services for pregnant and postpartum Medicaid members. Community health workers provide health advocacy, education, and navigation to support health-related social needs. Starting in 2024, coverage will expand to include children under 21 and special adult populations.

Objective 5. Promote Community-Based Organization Partnerships

- The Department of Health promotes partnerships with community-based organizations by requiring contracts with community-based organizations in certain value-based payment arrangements.
- In 2022, the Department of Health drafted an 1115 Waiver Amendment “New York Health Equity Reform” to advance health equity, reduce health disparities, and support the delivery of social care, which was approved by the Centers for Medicare & Medicaid Services in January 2024.
- The waiver aims to build partnerships with community-based organizations throughout the State in order to address social care needs. The Department of Health intends to emphasize the need for social needs screening for all Medicaid members, which will lead to referrals to needed services.

Objective 6. Improve the Health and Safety of Members’ Environments

- Social and environmental supports, including home modifications, are available to members in Managed Long-Term Care plans and some waiver participants. The Access to Home Medicaid program provides modifications like ramps, lifts, and handrails to help individuals with disabilities remain safely at home, improving quality of life and reducing healthcare costs. Many managed care plans offer social care interventions in collaboration with community-based organizations focused on neighborhood and environment.
- The Department of Health collaborates with the New York State Energy Research Development Authority on the Healthy Home Value-Based Payment Pilot, delivering interventions to 500 households in targeted regions to improve energy efficiency, weatherization, environmental trigger reduction, and home injury prevention. The pilot includes home visits from registered nurses and community health workers.
- The Department of Health Center for Environmental Health ensures the safety of New Yorkers’ environments through indoor air quality assessments for schools and public buildings, maintaining exposure risk registries, regulating water supplies, and developing injury prevention programs.

Objective 7. Promote a Sustainable Provider Workforce and Capacity

- The Department of Health’s New York Health Equity Reform Waiver Amendment focuses on workforce development through training programs, loan forgiveness, and workforce investments. In 2022, the Department created a Workforce Innovation Center to develop and evaluate programs to strengthen the State’s healthcare workforce and allocated \$1.2 billion for frontline healthcare worker bonuses. Significant increases to physician fee schedules were implemented in 2022 and 2023 to expand provider capacity in Medicaid.
- The Department of Health collects managed care plan provider network data via the Provider Network Data System and systematically reviews Medicaid and Child Health Plus networks against adequacy standards in each county. The Department communicates adequacy findings with each managed care plan and requires resolution of any network gaps.
- The Department of Health houses New York State Provider & Health Plan Look-Up website, a tool for consumers to search for available providers across plans and networks.
- The Department of Health’s external quality review organization completes access and availability studies using a “secret shopper” method to track provider availability and wait times.
- Increasing dental provider participation to improve dental access is a priority within the Medicaid and Child Health Plus programs. The first step in building interventions is a dental provider survey to gain insights about barriers and perspectives on Medicaid participation, fielded in late 2023.

Objective 8. Ensure and Incentivize High Quality Care

- The New York Health Equity Reform Waiver focuses on health disparities and systemic healthcare delivery issues. It aims to change how Medicaid integrates and pays for social, physical, and behavioral healthcare. A single statewide independent health equity regional organization will bring together diverse stakeholders to support data aggregation, regional needs assessment and planning, value-based payment design, and program evaluation.
- The Department of Health incentivizes high-quality care through existing programs. The Managed Care Quality Incentive Program offers premium bonuses based on performance in quality and patient satisfaction measures, combining quality of care, consumer satisfaction, and compliance measures. Quality Assurance Reporting Requirements data is publicly available at www.health.data.ny.gov . These quality measures also feed into the 5-Star Health Plan Quality Ratings Dashboard on the New York State Connector webpage, helping New Yorkers make informed health plan choices.
- The Patient-Centered Medical Home program offers financial incentives to primary care providers who demonstrate patient-centered, high-quality practices. Studies show the model delivers high-quality care while reducing costs, with lower average annual spend per member, fewer emergency department visits, and improved patient experience. The program incorporates equity through criteria such as social determinant of health interventions and culturally and linguistically appropriate services. The Department of Health continues to promote the program and plans to align a portion of the incentive payment with provider performance in line with the Centers for Medicare & Medicaid Services’ Making Care Primary program.

Objective 9. Improve Access to and Quality of Behavioral Healthcare

- The Department of Health has taken steps to remove barriers to behavioral health services, including promoting telehealth, covering non-emergency medical transportation to mental health and substance use services (not applicable to Child Health Plus), and allowing treatment in place by ambulance providers through the Emergency Triage, Treat, and Transport model until the federal program ends on December 31, 2023. Additionally, Medicaid managed care plans must report annually on behavioral health metrics via the Quality Assurance Reporting Requirements.

- The Department of Health partners with the Office of Mental Health and the Office of Addiction Services and Supports to create policies promoting the health and safety of Medicaid members with behavioral healthcare needs. The Collaborative Care Medicaid Program, run by the Office of Mental Health, incentivizes primary care providers who integrate mental health services. The Department of Health, the Office of Mental Health, and the Office of Addiction Services and Supports oversee the Integrated Outpatient Services license for clinics with integrated physical and behavioral health services, expanding service availability and improving care coordination.

Objective 10. Improve Access to and Quality of Dental Care

- The goal to “reduce dental caries among children” is part of the Prevention Agenda. The Department of Health is working toward three objectives: 1) increase the percentage of New York State residents served by optimally fluoridated community water systems by 9% to 77.5%; 2) decrease the percentage of children ages 1-17 with decayed teeth or cavities in the past year by 20% to 6.7%; and 3) increase the percentage of children ages 1-17 who had one or more preventive dental visits in the past year by 10% to 85.4%
- School-based health centers provide dental care directly to students in high-risk areas, with centers in 113 schools statewide.
- The Medicaid and Child Health Plus program covers teledentistry when clinically appropriate, allowing care through real-time audio-visual communication and the transmission of recorded information like charting, radiographs, and digital impressions.
- Medicaid and Child Health Plus allow non-dentist providers to apply fluoride varnish in primary care settings, facilitating quicker, less costly, and more convenient care.
- To improve access for patients with traumatic brain injury or intellectual and developmental disabilities, the Department of Health increased reimbursement for dental providers serving these populations. This includes a 20% enhancement over the fee schedule for all services provided by private practice dentists, separate reimbursement for multiple forms of sedation, and higher allowable units for dental surgery in ambulatory surgery centers.

Objective 11. Improve Access to and Quality of Maternal Healthcare

- The Department of Health’s Prevention Agenda aims to promote healthy women, infants, and children, tracking indicators such as maternal mortality, postpartum depression screening, and discussions with providers about healthy pregnancies.
- New York’s Medicaid program has implemented several initiatives to improve maternal healthcare, including updated policies and expanded prenatal and postpartum benefits.
- In 2023, Medicaid coverage was extended from 60 days postpartum to a full year following pregnancy.
- The Department of Health promotes Project TEACH, which offers consultations with reproductive psychiatrists, referrals to services, and education for providers and mothers. The Department will soon expand doula, midwifery, and other services for mothers and newborns.

Objective 12. Improve Access to and Quality of Home and Community Based Services

- Home- and community-based services are available to eligible individuals through many programs, including Managed Long-Term Care, Health and Recovery Plans (Adult Behavioral Home and Community Based Services and Community Oriented Recovery and Empowerment Services), Traumatic Brain Injury 1915c Waiver, Nursing Home Transition & Diversion 1915c Waiver, Community First Choice Option, Children’s Home and Community Based Services 1915c Waiver, Office of People With Developmental Disabilities’ Home- and Community-Based Services 1915c Waiver, Money Follows the Person Demonstration (described in Objective 4), and Child Health Plus Enrollees who are not eligible for Medicaid (as of January 1, 2025). Each program is uniquely designed to meet the needs of the individual and support them through integrated care. Specific

services may include care coordination, skill building, family and caregiver support services, crisis and planned respite, prevocational services, supported employment services, community advocacy and support, youth support and training, and non- medical transportation.

- The Department of Health also evaluates the quality of its home- and community-based services. The Managed Long-Term Care Program surveys members to measure satisfaction. The Health and Recovery Plan managed care plans must report on home- and community-based services-related measures. To support home- and community-based services during the public health emergency, the American Rescue Plan Act of 2021 increased the federal medical assistance percentage for certain Medicaid home- and community-based services expenditures by 10 percent. States may spend the funds through March 31, 2025. The Department of Health worked collaboratively with other state agencies to create a spending plan centered on 1) supporting and strengthening the direct care workforce, 2) home- and community-based capacity, Innovations and Systems Transformation, and 3) digital infrastructure investment. The 43 initiatives across these categories will enhance the critical services delivered through home- and community-based services.

Objective 13. Improve Access to and Quality of Patient-Centered Primary Care

- Over 2022 and 2023, New York State Medicaid invested millions in primary care by benchmarking Medicaid's fee-for-service physician reimbursement rates to 80% of Medicare and significantly increasing reimbursement for nurse practitioners and midwives. This is expected to boost the number of primary care providers participating with Medicaid and increase their capacity to see more Medicaid members.
- The Patient-Centered Medical Home program ensures that the primary care received by Medicaid and Child Health Plus members offers high care coordination and leads to positive quality outcomes.

Objective 14. Improve Access to and Quality of Care for Infants and Children

- Perinatal & Infant Health and Child & Adolescent Health are focus areas of the current Prevention Agenda, supported by the Title V Maternal and Child Health Services Block Grant. Goals include reducing infant mortality, promoting breastfeeding, supporting social-emotional development, aiding children with special healthcare needs, and preventing dental caries. These efforts ensure access to quality care for infants and children.
- The managed care program prioritizes postpartum and infant care. Medicaid managed care and Child Health Plus plans cover lactation counseling, and Medicaid has expanded eligible lactation counselor certifications. Doula services are currently covered via a pilot program for Medicaid, and the Department of Health is seeking a State Plan Amendment to cover prenatal, labor and delivery, and postpartum doula services. Medicaid and Child Health Plus coverage was recently extended to a full year following pregnancy.
- Various programs support children as they grow. The Early Intervention program provides services to children under age three with disabilities, and the Preschool/School Supportive Health Services Program continues these supports through age 21. The Child Teen Health Program ensures children receive critical screenings, well care exams, immunizations, mental healthcare, and dental care, using a holistic, person-centered approach.
- Children in foster care are categorically eligible for Medicaid and receive comprehensive health evaluations and individualized care plans. Most children under Volunteer Foster Care Agencies are enrolled in Medicaid Managed Care, which must comply with the Children's System Transformation Requirements and Standards. Volunteer Foster Care Agencies are licensed as 29-I Health Facilities, providing mandatory core health-related services with a trauma-informed approach. 29-I services are also covered in the Child Health Plus benefit package for children not eligible for Medicaid.
- In 2019, the Centers for Medicare & Medicaid Services' Innovation Center awarded the Department of Health a seven-year, \$16 million grant to implement the Integrated Care for Kids Model. This model aims to improve child health through early identification and treatment, combined with integrated care coordination. New

York's program with Montefiore Medical Center provides high-quality care for a medically complex and underserved population in the Bronx.

- As of 2022, nearly all Medicaid managed care plans had value-based payment contracts with a children's arrangement, including quality measurement for children enrolled in Medicaid and Child Health Plus. These arrangements emphasize value over volume, focusing on the healthy growth and development of children. They follow the "North Star" framework of goals, key indicators, and strategies for high-value children's healthcare. All plans with a children's arrangement report on the Child Quality Measure Set to demonstrate their performance.

Objective 15. Improve Access to and Quality of Chronic Disease Management

- New York State Medicaid provides tailored managed care for certain chronic disease populations and offers chronic disease management and education programs for all Medicaid members.
- HIV Special Needs Plans, offering the same benefits as mainstream Medicaid managed care plans plus specialized services, are available for Medicaid members with HIV/AIDS. Members can select an HIV specialist as their primary care provider. Over 15,000 Medicaid members were enrolled in HIV Special Needs Plans as of July 2023.
- The Health Home program offers comprehensive care management for Medicaid members with chronic health problems who meet eligibility criteria.
- The "In Lieu of Services" benefit provides Medically Tailored Meals for Medicaid members with chronic conditions to combat food insecurity and promote healthy, dietician-designed meals.
- Members with chronic diseases are encouraged to participate in self-management education programs, including the Chronic Disease Self-Management Program for arthritis, Diabetes Self-Management Training, Diabetes Prevention Program, and Asthma Self-Management Training. These programs provide education and tools to help adults manage chronic conditions and improve their quality of life.
- The Department of Health develops fact sheets for Medicaid and Child Health Plus members on various health topics, including chronic disease management.
- Managed care plans must report annually on chronic disease measures via Quality Assurance Reporting Requirements.

Objective 16. Increase Utilization of Preventive Healthcare Services

- The Vaccines for Children Program provides vaccines at no cost to children who are Medicaid-enrolled, Medicaid-expansion Children's Health Insurance Program-enrolled, underinsured, or uninsured. This program reduces the cost barrier to immunization, allowing children to receive immunizations at physicians' offices and public health clinics. Medicaid Managed Care and Child Health Plus cover preventive services with no cost sharing and conduct outreach to promote well-child and immunization schedules.
- The New York State Cancer Services Program offers breast, cervical, and colorectal cancer screenings and diagnostic services at no cost to uninsured or underinsured New Yorkers. The percentage of adults aged 50-64 receiving colorectal cancer screenings improved to 71.8% in 2021, exceeding the Prevention Agenda goal of 66.3% by 2024. However, the screening rate among Medicaid enrollees was 61% in 2021.
- New York State Medicaid Managed Care Programs cover a comprehensive smoking cessation benefit, including counseling and pharmacotherapy, without cost sharing, prior authorization, or limits on quit attempts. Medicaid also covers over-the-counter products like nicotine patches, gum, and lozenges.
- The Department of Health invests in primary care, an essential avenue for preventive care. The Fiscal Year 2024 New York State Executive Budget committed \$419 million to preventive and primary care.
- The Early and Periodic Screening, Diagnostic, and Treatment benefits ensure children under age 21 in Medicaid receive critical preventive care such as vaccinations and screenings, delivered in home or community-based settings whenever possible.

- Medicaid covers all Grade A and B preventive services recommended by the United States Preventive Services Task Force without cost sharing. This includes various cancer, mental health, and sexually transmitted disease screenings, tobacco cessation interventions, and preventive medications. New York State Medicaid updates its policy based on new recommendations to ensure access to high-quality, evidence-based preventive care.

Objective 17. Prevent Chronic Disease

- Across the Prevention Agenda focus areas, the Department of Health has outlined interventions to increase food security and access, improve environments for physical activity, prevent tobacco use initiation, and promote screenings and early disease detection for all New Yorkers.
- The state has developed comprehensive plans to end the AIDS epidemic and eliminate Hepatitis C as a public health problem by 2030. The Hepatitis C Elimination Plan addresses social and structural factors related to screening and treatment. One intervention is universal Hepatitis C screening for all pregnant women to reduce vertical transmission from mother to child.

Objective 18. Promote Data-Driven Medicaid Oversight and Health Plan Accountability

- The Department of Health’s Division of Health Plan Contracting and Oversight ensures compliance with policies and regulations, monitors plan performance, reviews contracts, and handles complaints for Medicaid Managed Care and Child Health Plus plans. Their work promotes health plan accountability and transparency.
- The Department of Health’s Division of Data Analytics and Services created various “databooks,” interactive visualizations for easy data access. A quality databook is under development to monitor metrics in the quality strategy and other key performance indicators, with filters for demographic categories, Department of Health programs, and health plan enrollment.
- To promote transparency, New York State makes a wide range of data publicly available on its website, Health Data New York. The Prevention Agenda dashboard provides state and county-level details on indicators. The Public Health Emergency Unwind Dashboard monitors insurance coverage with the end of continuous enrollment. The Managed Care Regional Consumer Guides provide details about the quality of care given by managed care plans.
- Incomplete race and ethnicity data has been a barrier to understanding disparities within New York State Medicaid and Child Health Plus programs. Recent adjustments to demographic questions in the NY State of Health application have improved race and ethnicity data among Qualified Health Plan enrollees. These changes are expected to improve data completeness within Medicaid and Child Health Plus programs as more manual enrollments occur post-public health emergency.

Objective 19. Promote Member Safety

- The Department of Health ensures patient safety through health plan and provider oversight, credentialing, and promoting safe practices. All New Yorkers, including Medicaid and Child Health Plus members, can make informed decisions about their healthcare providers using the New York State Physician Profile, which provides searchable information on providers’ education, board certifications, and any legal actions.
- New York State Medicaid and Child Health Plus offer several avenues for members to register concerns and complaints against providers and health plans, including a complaint helpline. The Managed Care Bill of Rights outlines the rights and protections for Medicaid managed care enrollees.
- In 2023, New York State Medicaid launched the NYRx pharmacy program, transitioning the pharmacy benefit from managed care plans to a single fee-for-service formulary for Medicaid members. This promotes patient safety and equity by establishing a uniform list of covered drugs with standardized rules and regulations. All mainstream Medicaid members now have access to the same pharmacy network and an improved process for obtaining medications.

Objective 20. Reduce Unnecessary Emergency Room Visits and Hospitalizations

- The Delivery System Reform Incentive Payment program concluded in 2020, but its legacy continues. A core goal was to reduce avoidable hospital use. New York State developed a Value Based Payment Roadmap to create a more efficient, high-quality, community-based healthcare system.
- The Health Home program provides comprehensive care management to Medicaid members with two or more chronic conditions or a single qualifying chronic condition. It links medical, behavioral, and social care providers, leading to more consistent care and fewer emergency room visits.
- The Medicaid Accelerated Exchange program supports interdisciplinary teams in reducing hospital admissions and emergency department use through collaborative workshops. Over 100 Medicaid Accelerated Exchange Action Teams have implemented effective pathways to assist patients at many medical centers statewide.
- The Department of Health has implemented social care initiatives like Medically Tailored Meals, Street Medicine, and Medical Respite to address social determinants of health. Seven Medicaid Managed Care organizations offer Medically Tailored Meals, improving health outcomes and reducing emergency room visits. Street Medicine and Medical Respite programs provide care to the homeless, aiming to reduce unnecessary emergency room visits and hospitalizations.
- The Centers for Medicare & Medicaid Services' Emergency Triage, Treat, and Transport Model allows ambulance teams to treat in place or transport to alternative destinations, like urgent care centers, when appropriate. This reduces healthcare costs and avoids unnecessary emergency room visits. Although the federal program ends on December 31, 2023, New York State is pursuing a State Plan Amendment to sustain and fund treatment in place.

Objective 21. Ensure Members are Able to Receive Care in the Least Restrictive Setting Possible

- Several of the initiatives previously described, such as Consumer Directed Personal Assistance Program and Home and Community Based Services waivers (Objective 4 and Objective 12), promotion of coordinated care through health homes and patient-centered medical home (Objective 2, Objective 8, and Objective 20), and reducing admissions via the Medicaid Accelerated Exchange (Objective 20), aim to improve and increase preventive care. These interventions ultimately improve the health and quality of life of Medicaid and Child Health Plus members, reducing the need for costlier downstream care.

IPRO's Assessment of New York State's Medicaid and Child Health Plus Quality Strategy

The New York State Medicaid and Child Health Plus Quality Strategy for January 2023-December 2025 generally aligns with the requirements of *Title 42 Code of Federal Regulations 438.340 Managed Care State Quality Strategy*. It serves as a guiding framework for managed care plans, aiming to increase access to health care, improve the quality of healthcare services delivered, and expand coverage to additional low-income New Yorkers. Eight clearly defined goals are supported by well-designed interventions, incorporating methods to measure and monitor progress through external quality review activities.

The strategy encompasses various quality improvement activities that focus on measurement and assessment, improvement, redesign, contract compliance and oversight, and enforcement. Improvement efforts are scaled through activities such as clinical focus studies, clinical and non-clinical performance improvement projects, quality incentives, the quality performance matrix, performance reports, quality improvement conferences and trainings, and managed care plan technical assistance.

From the baseline period measurement year 2021 to measurement year 2023, 11 metrics have either met or exceeded the 2025 targets. Focus areas that exceeded target performance included ensuring members are able

to receive care in the least restrictive setting possible ensuring coordinated care and promoting integrated care, improving the health and safety of members' environments, improving access to and quality of behavioral healthcare, improving access to and quality of maternal healthcare, improving access to and quality of care for infants and children, and improving access to and quality of chronic disease management. Four metrics were not collected as 2023 was a non-survey year for Child CAHPS and Quality of Home Health Aide/Personal Care Aide (Medicaid Managed Long-Term Care) and first year rates were not publicly reported for *Social Need Screening and Intervention* (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan) and *Topical Fluoride for Children* (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan).

Despite early positive outcomes, continued opportunities for enhancing health outcomes under the current strategy exist statewide. Twelve metrics that decreased from baseline year 2021 or remain unchanged include: Adult CAHPS: *Getting Care Quickly*, *Medicaid Enrolled Dentists*, *Proportion of Members in a Patient-Centered Medical Home*, *Adult Annual Dental Visit*, *Proportion of Members who Utilize Primary Care*, *Child and Adolescent Well-Care Visits*, *Follow-Up Care for Children Prescribed ADHD Medication - Continuation*, *Colorectal Cancer Screening* (electronic), *Childhood Immunization Status –Combination 10* (electronic), *Hepatitis C Elimination – Universal Screening for Pregnant People*, *Follow-Up After Hospitalization for Mental Illness – 7 Day*, and *Follow-Up After Hospitalization for Mental Illness – 30 Day*.

Recommendations to the New York State Department of Health

Per Title 42 Code of Federal Regulations 438.364 External quality review results (a)(4), this report is required to include recommendations on how the Department of Health can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to New York Medicaid managed care and Child Health Plus enrollees. As such, IPRO recommends the following to the Department of Health:

- The Department of Health should consider updating the target set for 2025 for the metrics that were already met and exceeded in measurement year 2023.
- The Department of Health should consider additional focus on member, provider, and Managed Care Plan outreach regarding increasing utilization of preventative healthcare services, of which both included metrics (colorectal cancer screening and childhood immunization status) decreased since baseline.
- Overall, performance measurement is progressing towards target goals at this mid-point in the quality strategy plan. Quantitative and qualitative data should continue to be collected to identify successes, best practices, barriers, challenges and opportunities across quality improvement focus areas.
- To increase the transparency and overall understanding of state-led compliance review activities, the Department of Health should consider revising related policies and procedures, and technical methods of data collection and analysis.
- Although quality rating protocols have not yet been issued by the Centers for Medicare & Medicaid Services, the Department of Health should consider including the results of its Consumer Guide Star Rating as a component of the annual external quality review report.

Medicaid Managed Long-Term Care Plan Profiles

There are three types of Medicaid Managed Long-Term Care plans: Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly. In 2023, there were 12 approved Medicaid Advantage Plus plans; 23 Partial Capitation plans; and 9 Program of All-Inclusive Care for the Elderly plans. Descriptions of the Managed Long Term Care plan types are in **Table 6**.

Table 6: Managed Long-Term Care Plan Types

Managed Long-Term Care Plan Types
Medicaid Advantage Plus
Medicaid Advantage Plus plans must be certified by the Department of Health as a Managed Long-Term Care plan and by the Centers for Medicare & Medicaid Services as a Medicare Advantage plan. Medicaid Advantage Plus plans receive capitation payments from both Medicaid and Medicare. The Medicaid benefit package includes long-term care and behavioral health services, and the Medicare benefit package includes ambulatory care and inpatient services.
Partial Capitation
Managed Long-Term Care Partial Capitation is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or day care, are provided through Managed Long-Term Care plans that are approved by the Department of Health. Ambulatory care and inpatient services are paid by Medicare if the member is dually eligible for both Medicare and Medicaid, or by Medicaid if the member is not Medicare eligible. Medicaid capitation payments are provided to Partial Capitation plans to cover the costs of long-term care and selected ancillary services. Dual eligible individuals (having both Medicare and Medicaid), who are age 21 and older and who are assessed as needing community based long term care services for more than 120 days must enroll in Managed Long-Term Care in order to receive those services. The following may voluntarily enroll in Managed Long-Term Care: <ul style="list-style-type: none">a. dual eligible individuals, age 18–20, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days; andb. non–dual eligible individuals, age 18 and older, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days.
Program of All-Inclusive Care for the Elderly
The Program of All-Inclusive Care for the Elderly provides a comprehensive system of health care services for members 55 years of age and older, who are otherwise eligible for nursing home admission. Both Medicaid and Medicare pay for Program of All-Inclusive for the Elderly services on a capitated basis. Under this program, members are required to use Program of All-Inclusive Care for the Elderly physicians. An interdisciplinary team develops a care plan and provides ongoing care management. This type of Managed Long-Term Care plan is responsible for directly providing or arranging all primary, inpatient hospital, and long-term care services needed by the member. The type of managed care plan is approved by both the Centers for Medicare & Medicaid Services and the Department of Health.

Table 7 displays enrollment data for each Managed Long-Term Care plan. For each managed care plan type, the table displays the formal and abbreviated names of the managed care plan, and the total Medicaid enrollment as of December 2023.

Table 7: Managed Long-Term Care Profiles

Managed Long-Term Care Plan	Enrollment as of 12/2023 ¹
Medicaid Advantage Plus	42,252
AgeWell New York Advantage Plus (AgeWell) ²	85
Centers Plan for Medicaid Advantage Plus (Centers Plan)	1,553
Elderplan, Inc. MAP (Elderplan)	3,647
Empire Blue Cross Blue Shield HealthPlus Duals Plus (Empire BCBS HealthPlus)	116
Fidelis Medicaid Advantage Plus (Fidelis Care)	1,131
Hamaspik Inc. (Hamaspik)	852
MetroPlus Ultracare (MetroPlus)	173
MHI Healthfirst CompleteCare (MHI Healthfirst)	27,649
RiverSpring MAP (RiverSpring)	282
Senior Whole Health of New York MAP (Senior Whole Health)	249
VillageCareMAX Medicare Total Advantage (VillageCare)	2,629
VNS Health Total (VNS Health)	3,886
Partial Capitation	281,303
Aetna Better Health (Aetna)	6,070
ArchCare Community Life (ArchCare)	5,870
Centers Plan for Healthy Living (Centers Plan)	52,418
Elderwood Health Plan (Elderwood)	1,169
Empire Blue Cross Blue Shield HealthPlus MLTC (Empire BCBS HealthPlus)	56,458
EverCare Choice (EverCare)	767
Extended MLTC, LLC (Extended MLTC) ³	No Enrollment
Fallon Health Weinberg-MLTC (Fallon Health) ⁴	467
Fidelis Care at Home (Fidelis Care)	17,665
Hamaspik Choice, Inc. (Hamaspik)	7,649
HomeFirst, a product of Elderplan, Inc. (Elderplan)	21,444
iCircle Care (iCircle)	3,624
Kalos Health	850
MetroPlus MLTC (MetroPlus)	1,620
Montefiore Diamond Care (Montefiore) ⁵	1,235
Nascentia Health (Nascentia)	5,026
Prime Health Choice, LLC (Prime Health)	572
RiverSpring at Home (RiverSpring)	17,098
Senior Health Partners a Healthfirst Company (Senior Health Partners)	9,182
Senior Network Health, LLC (Senior Network Health)	342
Senior Whole Health of New York MLTC (Senior Whole Health)	27,410
VillageCareMAX (VillageCare)	20,608
VNS Health MLTC (VNS Health)	23,759

Managed Long-Term Care Plan	Enrollment as of 12/2023 ¹
Program of All-Inclusive Care for the Elderly	9,505
ArchCare Senior Life (ArchCare)	799
Catholic Health-LIFE (Catholic Health)	228
CenterLight Healthcare PACE (CenterLight)	6,379
Complete Senior Care	133
Eddy SeniorCare	370
Fallon Health Weinberg-PACE (Fallon Health)	161
Independent Living for Seniors dba ElderONE (ElderONE)	750
PACE CNY	558
Total Senior Care, Inc. (Total Senior Care)	127

¹ Data Sources: New York State Department of Health Managed Long-Term Care Plan Directory, Revised July 2024. Website: https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm; and New York State Department of Health Medicaid Managed Care Enrollment Report, December 2023. Website: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

² AgeWell Medicaid Advantage Plus announced a withdrawal effective 12/31/2023.

³ Extended MLTC, LLC Partial Capitation Plan was acquired by Hamaspik Choice, Inc. MLTC Partial Capitation Plan on 8/1/2023.

⁴ Fallon Health Weinberg MLTC Partial Capitation Plan announced a withdrawal effective 12/31/2023.

⁵ Montefiore Diamond Care Partial Capitation Plan was acquired by RiverSpring/ElderServe MLTC Partial Capitation Plan on 12/31/2023.

External Quality Review Activity 1. Validation of Performance Improvement Projects

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Survey

Managed Long-Term Care plans do projects to improve the value or quality of health care for New Yorkers. These types of projects are called performance improvement projects. New York’s Managed Long-Term Care plans are required to conduct a performance improvement project every year. The New York State Department of Health and Managed Long-Term Care plans select topics for performance improvement projects.

IPRO reviews these projects to verify if they were conducted in a logical way. This is called “validation.” Each year, IPRO validates the performance improvement projects conducted by the Managed Long-Term Care plans.

In 2023, the Managed Long-Term Care performance improvement project topic was Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership.

2023 Performance Improvement Projects Summary

Validation Process

- Does the report have a topic, identify a population, have a clear and meaningful focus?
- Are the Managed Long-Term Care plan's sampling methods, data collection steps, and results reliable?
- Are the improvement strategies appropriate? Was there an improvement?

Validation Results

- All performance improvement projects passed validation.

Performance Improvement Project Results

- All of the Managed Long-Term Care plans had or developed a standalone social determinants of health assessment tool.
- All Medicaid Advantage Plus (12) & Program of All-Inclusive Care for the Elderly (9) Managed Long-Term Care plans demonstrated improvement from baseline to final measurement year in three or more project indicators.
- 91%** (20 of 22) of the Partial Capitation Managed Long-Term Care plans demonstrated improvement from baseline to final measurement year in three or more project indicators.

For more information about validation of performance improvement projects, please read the rest of this section.

Technical Summary – Validation of Performance Improvement Projects

Objectives

Title 42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program (d) Performance improvement projects establishes that the state must require contracted Medicaid managed care plans to conduct performance improvement projects that focus on both clinical and non-clinical areas. According to the Centers for Medicare & Medicaid Services, the purpose of a performance improvement project is to assess and improve the processes and outcomes of health care provided by a managed care plan. Further, managed care plans are required to design performance improvement projects to achieve significant, sustained improvement in health outcomes, and that include the following elements:

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

As required by *Partial Capitation Article V(F)*, *Medicaid Advantage Plus Section 16.1-16.5* and *Program of All-Inclusive Care for the Elderly Article III (D)*, New York State Managed Long-Term Care plans must conduct at least one performance improvement project in a priority topic area of its choosing with the mutual agreement of the Department of Health and the external quality review organization, and consistent with federal requirements. Beginning in 2022 and continuing through 2023, the Managed Long-Term Care plans were required to conduct the performance improvement project: *Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership*.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for the Managed Long-Term Care plans' *Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership* performance improvement projects.

While interventions are managed care plan-specific, the performance improvement project focus area and performance indicators are consistent across the Managed Long-Term Care plans. The *Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership* project aims to increase managed care plan screening and follow-up related to social determinants of health among the Managed Long-Term Care population. Descriptions of the five required performance indicators are in **Table 8**: .

Table 8: Required Performance Improvement Project Indicators, 2022-2023

Indicator	Numerator	Denominator
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	Number of newly enrolled members with a completed stand-alone social determinants of health assessment within first 30 days of enrollment (<i>Assessment must address housing security, safety, food insecurity, social isolation, and financial insecurity.</i>)	Number of members newly enrolled within the last 6 months of the measurement year
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	Number of continuously enrolled members with a completed stand-alone social determinants of health assessment in the measurement year	Number of members continuously enrolled longer than 6 months in the measurement year
Percentage of care manager contacts where a social determinants of health screen is conducted	Number of care manager contacts where a social determinants of health screening or assessment was conducted as part of the contact	Number of care manager contacts within the measurement year
Percentage of members with a positive social determinants of health assessment	Number of members with a documented need resulting from a completed social determinants of health assessment (<i>One or more needs is a positive assessment.</i>)	Number of members with a completed social determinants of health assessment within the measurement year
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	Number of members with documented actions taken to address need	Number of members with a documented need resulting from a completed social determinants of health assessment

Technical Methods for Data Collection and Analysis

The Centers for Medicare & Medicaid Services’ *Protocol 1 – Validation of Performance Improvement Projects* was used as the framework to assess the quality of each performance improvement project, as well as to score the compliance of each performance improvement project with both federal and state requirements. IPRO’s evaluation involves the following elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan’s enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the managed care plan’s enrollment and generalizable to the managed care plan’s total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the performance improvement project.

5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is “real” improvement.
10. Assessment of whether the managed care plan achieved sustained improvement.

Following review of the listed elements, findings were assessed to determine if they should be accepted as valid and reliable. The element was then determined to be “met” or “not met.” While elements 1-8 are reviewed each year that the performance improvement project is in progress, elements 9 and 10 are included in the review the year that the performance improvement project concludes. As the performance improvement projects concluded at the end of 2023, IPRO reviewed elements 1-10 as part of the validation activity for measurement year 2023.

A determination was made as to the overall credibility of the results of each performance improvement project, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
- The validation findings generally indicate that the credibility for the performance improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the performance improvement project results. The concerns that put the conclusion at risk are enumerated.

A performance improvement project may have had no validation findings indicating that the credibility of the results was at risk, but the plan may have still received a Statement of Deficiency during their compliance review due to having failed to meet required timeliness deadlines to develop an acceptable quality assurance program.

IPRO provided performance improvement project report templates to each Managed Long-Term Care plan for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

Description of Data Received

For the 2023 external quality review, IPRO reviewed Managed Long-Term Care plan performance improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO’s assessment of each Managed Long-Term Care plan’s performance improvement project methodology revealed there were no validation findings indicating that the credibility of the performance improvement project results was at risk. Summaries of the validation assessments are in **Table 9** for Medicaid Advantage Plus, **Table 10** for Partial Capitation Plans, and **Table 11** for Program of All-Inclusive Care for the Elderly Plans. Performance indicator rates are in **Table 12**, **Table 13**, and **Table 14**.

Details of each managed care plan’s performance improvement project activities are described in the **Managed Long-Term Care Plan-Level Reporting** section of this report.

Table 9: Medicaid Advantage Plus Performance Improvement Project Validation Findings, Measurement Year 2023

Medicaid Advantage Plus Performance Improvement Project Validation Elements and Results										
Medicaid Advantage Plus Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods ¹	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement ²	Achieved Sustained Improvement ³
AgeWell ⁴	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Centers Plan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Elderplan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Hamaspik	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MHI Healthfirst	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
RiverSpring	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Senior Whole Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VillageCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VNS Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met

¹ **Sampling Methods** were not applied by the managed care plan (the study population includes all eligible members) and therefore the element was not included in the validation review.

² **Achieved Real Improvement** was determined as met if the plan demonstrated a strong, sustainable foundation to continue to address the social determinants of health needs of their members.

³ **Achieved Sustained Improvement** was determined as met if the plan demonstrated improvement from baseline to final measurement year in three or more project indicators. If baseline measurement year rates were not available, final measurement year rates were compared to interim measurement year rates.

⁴ AgeWell Medicaid Advantage Plus announced a withdrawal effective 12/31/2023.

Table 10: Partial Capitation Performance Improvement Project Validation Findings, Measurement Year 2023

Partial Capitation Performance Improvement Project Validation Elements and Results										
Partial Capitation Plans	Selected Topic	Study Question	Indicators	Population	Sampling Methods ¹	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement ²	Achieved Sustained Improvement ³
Aetna	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
ArchCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Centers Plan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Elderplan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Elderwood	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
EverCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Not Met
Fallon Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Hamaspik ⁴	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
iCircle	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Kalos Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Montefiore	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Nascentia	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Prime Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Not Met
RiverSpring	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Senior Health Partners	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Senior Network Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Senior Whole Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VillageCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VNS Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met

¹ **Sampling Methods** were not applied by the managed care plan (the study population includes all eligible members) and therefore the element was not included in the validation review.

² **Achieved Real Improvement** was determined as met if the plan demonstrated a strong, sustainable foundation to continue to address the social determinants of health needs of their members.

³ **Achieved Sustained Improvement** was determined as met if the plan demonstrated improvement from baseline to final measurement year in three or more project indicators. If baseline measurement year rates were not available, final measurement year rates were compared to interim measurement year rates.

⁴ Hamaspik acquired Extended MLTC's membership on 8/1/2023.

Table 11: Program of All-Inclusive Care for the Elderly Performance Improvement Project Validation Findings, Measurement Year 2023

Program of All-Inclusive for the Elderly Performance Improvement Project Validation Elements and Results										
Program of All-Inclusive Care for the Elderly Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods ¹	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement ²	Achieved Sustained Improvement ³
ArchCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Catholic Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
CenterLight	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Complete Senior Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Eddy SeniorCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
ElderONE	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Fallon Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
PACE CNY	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Total Senior Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met

¹ **Sampling Methods** were not applied by the managed care plan (the study population includes all eligible members) and therefore the element was not included in the validation review.

² **Achieved Real Improvement** was determined as met if the plan demonstrated a strong, sustainable foundation to continue to address the social determinants of health needs of their members.

³ **Achieved Sustained Improvement** was determined as met if the plan demonstrated improvement from baseline to final measurement year in three or more project indicators. If baseline measurement year rates were not available, final measurement year rates were compared to interim measurement year rates.

Table 12: Medicaid Advantage Plus Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2023

Medicaid Advantage Plus Performance Improvement Project Indicator Rates					
Medicaid Advantage Plus	Percentage of New Enrollees with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Continuously Enrolled Members with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Care Manager Contacts Where a Social Determinants of Health Screen is Conducted	Percentage of Members with a Positive Social Determinants of Health Assessment	Percentage of Members with a Positive Social Determinants of Health Assessment Who Have Documented Interventions to Address Need(s)
AgeWell ¹	47.92%	47.69%	20.56%	4.08%	100.00%
Centers Plan	83.27%	98.66%	92.38%	5.95%	93.33%
Elderplan	98.36%	100.00%	99.53%	26.65%	52.89%
Empire BCBS HealthPlus	100.00%	58.88%	Not Available	4.76%	100.00%
Fidelis Care	76.07%	91.85%	98.97%	25.34%	98.80%
Hamaspik	20.45%	67.92%	52.29%	30.58%	94.44%
MetroPlus	70.83%	87.72%	10.34%	28.40%	97.83%
MHI Healthfirst	86.59%	92.91%	9.95%	8.93%	98.85%
RiverSpring	88.35%	36.10%	24.07%	4.35%	71.43%
Senior Whole Health	89.71%	88.96%	18.07%	15.52%	88.89%
VillageCare	90.35%	73.73%	6.49%	15.98%	69.35%
VNS Health	42.75%	84.57%	15.88%	14.39%	91.60%

¹ AgeWell Medicaid Advantage Plus announced a withdrawal effective 12/31/2023.

Table 13: Partial Capitation Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2023

Partial Capitation Performance Improvement Project Indicator Rates						
Partial Capitation Plan	Percentage of New Enrollees with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Continuously Enrolled Members with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Care Manager Contacts Where a Social Determinants of Health Screen is Conducted	Percentage of Members with a Positive Social Determinants of Health Assessment	Percentage of Members with a Positive Social Determinants of Health Assessment Who Have Documented Interventions to Address Need(s)	
Aetna	60.26%	11.08%	19.95%	74.94%	96.22%	
ArchCare	69.66%	95.64%	40.16%	13.06%	64.67%	
Centers Plan	95.46%	99.39%	92.33%	3.79%	82.48%	
Elderplan	98.96%	100.00%	99.61%	21.32%	43.27%	
Elderwood	80.37%	67.11%	13.34%	41.18%	93.41%	
Empire BCBS HealthPlus	98.05%	76.25%	77.82%	0.26%	32.02%	
EverCare	99.52%	86.36%	16.04%	3.89%	62.96%	
Fallon Health	96.43%	94.48%	99.13%	20.80%	89.71%	
Fidelis Care	77.57%	84.34%	98.56%	17.79%	96.28%	
Hamaspik	61.29%	80.74%	12.99%	9.62%	96.94%	
iCircle	82.78%	94.37%	33.26%	37.49%	100.00%	
Kalos Health	90.34%	66.67%	12.21%	99.24%	99.34%	
MetroPlus	79.23%	93.01%	11.55%	23.96%	96.30%	
Montefiore	93.06%	96.42%	16.07%	1.86%	95.24%	
Nascentia	63.77%	86.15%	86.79%	48.92%	31.51%	
Prime Health	40.43%	78.08%	16.13%	43.56%	90.90%	
RiverSpring	73.03%	88.13%	18.45%	4.02%	63.25%	
Senior Health Partners	73.21%	85.43%	8.27%	9.14%	98.55%	
Senior Network Health	94.00%	89.58%	9.72%	83.39%	100.00%	
Senior Whole Health	89.67%	94.24%	25.41%	4.54%	29.68%	
VillageCare	87.25%	76.97%	8.04%	14.60%	65.00%	
VNS Health	68.52%	85.05%	17.45%	14.95%	90.44%	

Table 14: Program of All-Inclusive Care for the Elderly Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2023

Program of All-Inclusive for the Elderly Performance Improvement Project Indicator Rates					
Program of All-Inclusive Care for the Elderly Plan	Percentage of New Enrollees with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Continuously Enrolled Members with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Care Manager Contacts Where a Social Determinants of Health Screen is Conducted	Percentage of Members with a Positive Social Determinants of Health Assessment	Percentage of Members with a Positive Social Determinants of Health Assessment Who Have Documented Interventions to Address Need(s)
ArchCare	70.33%	60.66%	66.18%	14.10%	97.30%
Catholic Health	100.00%	100.00%	100.00%	0.00%	Not Applicable
CenterLight	93.82%	93.95%	72.50%	13.20%	98.75%
Complete Senior Care	89.66%	98.69%	89.47%	42.37%	100.00%
Eddy SeniorCare	98.66%	97.75%	97.97%	17.42%	99.30%
ElderONE	98.28%	99.64%	25.60%	2.36%	100.00%
Fallon Health	92.86%	65.91%	71.28%	99.49%	100.00%
PACE CNY	100.00%	100.00%	100.00%	95.12%	100.00%
Total Senior Care	18.18%	94.53%	17.85%	3.06%	100.00%

External Quality Review Activity 2. Validation of Performance Measures

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans collect information on the health status of New Yorkers enrolled in Medicaid and the services they receive. They share this information with the New York State Department of Health and its partners in many ways. One way is through performance measures.

The performance measures show how well the managed care plans are caring for their members. For this reason, the Department of Health monitors the performance measures regularly. A performance measure describes health care and health status using numbers. These numbers are percentages or rates. Performance measure rates often use the “%” symbol.

The Department of Health uses the information submitted by the Managed Long-Term Care plans to calculate performance measure rates. The information used to calculate the rates must be accurate and complete. To ensure data accuracy and completeness, IPRO reviews the New York State Department of Health’s methods for calculating a selection of rates as part of the performance measure validation process.

2023 Performance Measure Validation Summary

Validation Process	<ul style="list-style-type: none"> • Are reporting practices and performance measure specifications compliant? • Is each performance measure accurate? Is it complete?
Validation Results	<ul style="list-style-type: none"> • IPRO validated six performance measures that were calculated by the Department of Health.
Performance Measure Rates	<ul style="list-style-type: none"> • Of the Medicaid Advantage Plus rates included in this report, 31% performed statistically significantly better than statewide Managed Long-Term Care performance; 18% performed statistically significantly worse than statewide Managed Long-Term Care performance; and 51% did not differ in performance from statewide Managed Long-Term Care performance. • Of the Partial Capitation rates included in this report, 37% performed statistically significantly better than statewide Managed Long-Term Care performance; 39% performed statistically significantly worse than statewide Managed Long-Term Care performance; and 24% did not differ in performance from statewide Managed Long-Term Care performance. • Of the Program of All-Inclusive Care for the Elderly rates included in this report, 30% performed statistically significantly better than statewide Managed Long-Term Care performance; 35% performed statistically significantly worse than statewide Managed Long-Term Care performance; and 35% did not differ in performance from statewide Managed Long-Term Care performance.

For more information about validation of performance measures, please read the rest of this section.

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must identify standard performance measures relating to the performance of managed care plans and that the state requires each managed care plan to annually submit data enabling the state to calculate performance for these standards measures. The *Uniform Assessment System for New York Community Health Assessment* is a web-based clinical assessment tool based on a uniform data set, which uses a standardized approach to assessments for home- and community-based programs. The Department of Health calculates performance measures using data collected through the *Uniform Assessment System for New York Community Health Assessment*.

Managed Long-Term Care enrollees are assessed at enrollment, thereafter annually, and earlier in the event of a significant change in status. The *Community Health Assessment* is used by the Managed Long-Term Care plans to conduct these assessments. The Department of Health reports member-level information to the Managed Long-Term Care plans nightly and calculates performance measure reports annually.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for measurement year 2023.

Technical Methods of Data Collection and Analysis

The Managed Long-Term Care plans conduct assessments either directly with their own nursing staff, or through subcontractors. The Department of Health requires the *Community Health Assessment* to be completed by a registered nurse. Each year, a static file is generated from the *Uniform Assessment System for New York* containing the most recent *Community Health Assessment* for enrollees in each Managed Long-Term Care plan from January through December.

For measurement year 2023, IPRO validated the Department of Health's ability to:

- collect appropriate and accurate data through the *Community Health Assessment*,
- manipulate the data through programmed queries,
- internally validate results of the operations performed on the data sets,
- follow technical specifications for calculating performance measures, and
- report the measures appropriately.

The *Community Health Assessment* measures selected for validation and presented in this report are displayed in **Table 15**.

Table 15: Community Health Assessment Categories and Measures

Domain/Measure	Question in Community Health Assessment	Numerator Specifications	Denominator Specifications
Preventive Care			
No Shortness of Breath	Dyspnea	Members who did not experience shortness of breath	All members
No Severe Daily Pain	Pain frequency and pain intensity	Members who did not experience severe or excruciating pain daily or on 1-2 days over the last 3 days	All members
Pain Controlled	Pain frequency and pain control	Members who did not experience uncontrolled pain	All members
Not Lonely or Not Distressed	Lonely, social activities, time alone, stressors, self-reported depressed feelings, and withdrawal	Members who were not lonely or did not experience any of the following: decline in social activities, eight or more hours alone during the day, major life stressors, self-reported depression, or withdrawal from activities	All members
Effectiveness of Care			
Influenza Vaccination	Influenza vaccine	Members who received an influenza vaccine in the last year	All members
Pneumococcal Vaccination	Pneumovax vaccine	Members, age 65 or older, who received a pneumococcal vaccine in the last five years or after age 65	All members, age 65 and over
COVID-19 Vaccination	COVID-19 vaccine	Members who received a COVID-19 vaccine in the last year or as required	All members

IPRO evaluated both *Uniform Assessment System for New York* and *Selected Managed Long-Term Care Measures* data dictionaries for reliability, as well as reviewed source code provided by the Department of Health for reasonability, and to ensure that the measure specifications were adhered to for measure calculation.

Description of Data Obtained

For the 2023 external quality review, the Department of Health provided IPRO with pertinent documentation to support the performance measure validation process, including final calculated rates. Specifically, IPRO received the *Dictionary of Selected Managed Long-Term Care Measures* (February 2023), the *full Data Dictionary for Uniform Assessment System for New York Version 1.16.x* (November 2023), a print version of *the Uniform Assessment System for New York Community Health Assessment* (June 2023), and SAS® source code used by the Department of Health to calculate performance rates for the measures in **Table 16**, **Table 17**, and **Error! Reference source not found.**

The *Dictionary of Selected Managed Long-Term Care Measures* (February 2023) provided definitions for each measure in the *Uniform Assessment System for New York*, including name, type (descriptive–mean, descriptive–prevalence, quality–over-time, quality–prevalence, satisfaction–prevalence, utilization–statewide prevalence), numerator and denominator specifications, exclusion criteria, and clarifying comments to assist result interpretation.

The *full Data Dictionary for Uniform Assessment System for New York Version 1.16.x* (November 2023) provides the technical file layout of the Uniform Assessment System for New York’s user interface, including table name, XML property name, field name, question text, sub question text, list of values, list of values name, list of values identification codes, list of values description, variable type and length, and response options.

The print version of the *Uniform Assessment System for New York Community Health Assessment* (June 2023) displays the information collected during an assessment and response options.

Comparative Results

The results of IPRO’s performance measure validation activities determined the Department of Health successfully calculated and reported rates for measurement year 2023 using data deriving from the *Uniform Assessment System for New York Community Health Assessment*. There were no issues found within the Department of Health’s source code, and the coding logic abided by data dictionary requirements to accurately generate the desired calculations.

Table 16, **Table 17**, and **Error! Reference source not found.** present Managed Long-Term Care plan performance measure rates for Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly, respectively. These tables also display statewide Managed Long-Term Care program performance.

Table 16: Medicaid Advantage Plus Performance Measure Results

Medicaid Advantage Plus Quality Measures and Rates							
Medicaid Advantage Plus	No Shortness of Breath	No Severe Daily Pain	Pain Controlled	Not Lonely or Not Distressed	Influenza Vaccination	Pneumococcal Vaccination	COVID-19 Vaccination
Statewide Managed Long-Term Care Average ¹	68%	96%	98%	99%	78%	80%	76%
AgeWell	64%	89%	100%	100%	67%	57%	Small Sample
Centers Plan	44%	87%	99%	99%	76%	88%	45%
Elderplan	37%	99%	99%	100%	78%	85%	81%
Empire BCBS HealthPlus	89%	100%	100%	100%	82%	87%	81%
Fidelis Care	73%	87%	96%	99%	69%	71%	78%
Hamaspik	69%	98%	98%	98%	77%	80%	67%
MetroPlus	86%	100%	97%	100%	76%	76%	89%
MHI Healthfirst	84%	97%	96%	97%	73%	75%	73%
RiverSpring	49%	96%	87%	97%	85%	79%	84%
Senior Whole Health	83%	99%	100%	100%	88%	89%	93%
VillageCare	84%	98%	99%	99%	80%	80%	73%
VNS Health	88%	98%	98%	99%	85%	91%	88%

¹ Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

Green shading indicates that the managed care plan’s 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan’s performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions. **Small Sample:** Denominator was too small (e.g., less than 30) to report a valid rate.

Table 17: Partial Capitation Performance Measure Results

Partial Capitation Quality Measures and Rates							
Partial Capitation	No Shortness of Breath	No Severe Daily Pain	Pain Controlled	Not Lonely or Not Distressed	Influenza Vaccination	Pneumococcal Vaccination	COVID-19 Vaccination
Statewide Managed Long-Term Care Average ¹	68%	96%	98%	99%	78%	80%	76%
Aetna	86%	98%	98%	99%	82%	83%	83%
ArchCare	81%	95%	97%	98%	72%	66%	79%
Centers Plan	46%	86%	99%	99%	79%	88%	52%
Elderplan	47%	99%	99%	100%	78%	81%	78%
Elderwood	50%	95%	89%	89%	68%	64%	73%
Empire BCBS HealthPlus	74%	100%	99%	100%	83%	82%	84%
EverCare	66%	94%	91%	97%	74%	80%	68%
Extended MLTC ²	71%	99%	98%	100%	78%	77%	83%
Fallon Health	40%	95%	90%	88%	45%	46%	38%
Fidelis Care	73%	92%	97%	99%	66%	66%	75%
Hamaspik	53%	99%	99%	99%	75%	85%	46%
iCircle	43%	78%	82%	86%	69%	76%	65%
Kalos Health	58%	100%	98%	96%	72%	83%	78%
MetroPlus	92%	98%	96%	99%	78%	77%	84%
Montefiore	68%	97%	85%	92%	81%	73%	83%
Nascentia	50%	95%	93%	97%	71%	76%	76%
Prime Health	66%	99%	99%	100%	79%	81%	87%
RiverSpring	43%	99%	90%	98%	65%	60%	70%
Senior Health Partners	86%	98%	98%	98%	71%	68%	73%
Senior Network Health	39%	89%	90%	93%	77%	71%	73%
Senior Whole Health	76%	99%	99%	99%	83%	87%	89%
VillageCare	83%	99%	99%	99%	79%	80%	84%
VNS Health	84%	99%	98%	99%	78%	86%	84%

¹ Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

² Extended MLTC was acquired by Hamaspik on 8/1/2023.

Green shading indicates that the managed care plan’s 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions. **Red shading** indicates that the managed care plan’s performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Table 18: Program of All-Inclusive Care for the Elderly Performance Measure Results

Program of All-Inclusive Care for the Elderly Quality Measures and Rates							
Program of All-Inclusive Care for the Elderly	No Shortness of Breath	No Severe Daily Pain	Pain Controlled	Not Lonely or Not Distressed	Influenza Vaccination	Pneumococcal Vaccination	COVID-19 Vaccination
Statewide Managed Long-Term Care Average ¹	68%	96%	98%	99%	78%	80%	76%
ArchCare	85%	98%	98%	99%	85%	85%	83%
Catholic Health	44%	96%	91%	94%	94%	87%	98%
CenterLight	95%	99%	99%	100%	89%	68%	91%
Complete Senior Care	23%	90%	84%	47%	84%	78%	90%
Eddy SeniorCare	45%	93%	87%	91%	90%	91%	87%
ElderONE	51%	98%	96%	96%	84%	67%	80%
Fallon Health	51%	95%	93%	93%	80%	68%	93%
PACE CNY	48%	96%	95%	92%	83%	83%	84%
Total Senior Care	51%	82%	78%	75%	69%	68%	83%

¹ Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

Green shading indicates that the managed care plan’s 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan’s performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Survey

The United States Department of Health & Human Services determines how the Medicaid program should work. The Department of Health & Human Services created a set of rules for states and Medicaid managed care plans to follow. These rules are called Medicaid standards. These Medicaid standards protect people who receive health care through state Medicaid programs. All Medicaid managed care plans in the country are required to follow these standards.

The Department of Health is responsible for making sure that the New York Managed Long-Term Care plans follow the Medicaid standards. The Department of Health continuously monitors the Managed Long-Term Care plans using a variety of mechanisms. The main way that the Managed Long-Term Care plans are monitored is through the Managed Care Operational Survey⁹. During the survey, the Department of Health reviews Medicaid managed care plan documents and interviews plan staff. The Medicaid managed care plan is responsible for fixing any issues found during the survey.

For more information about the review of compliance with Medicaid Standards, please read the rest of this section.

⁹ The Managed Care Operational Survey is conducted by the New York State Department of Health for Medicaid Advantage Plus and Partial Capitation managed care plans. Medicaid compliance oversight for Program of All-Inclusive Care for the Elderly managed care plans is conducted and reported on by the Centers for Medicare & Medicaid Services.

Technical Summary – Review of Compliance with Medicaid and Children’s Health Insurance Program Standards

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a managed care plan’s compliance with the standards set forth in *42 Code of Federal Regulations Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards*, the disenrollment requirements and limitations described in *42 Code of Federal Regulations 438.56*, the enrollee rights requirements described in *Title 42 Code of Federal Regulations 438.100*, the emergency and post-stabilization services requirements described in *Title 42 Code of Federal Regulations 438.114*, and the quality assessment and performance improvement requirements described in *42 Code of Federal Regulations 438.330*. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Department of Health conducts a variety of oversight activities to ensure that the managed care plans are in compliance with federal and state requirements and the applicable standards of *Title 42 Code of Federal Regulations Part 438 Managed Care*, the *Medicaid Advantage Plus Model Contract*, the *Managed Long-Term Care Partial Capitation Model Contract*, the *Program of All-Inclusive Care for the Elderly Managed Long-Term Care Model Contract*, *New York State Public Health Law Article 44 and Article 49*, and *Title 10 of the New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*. These oversight activities include the Managed Care Operational Survey and focused surveys. These survey activities center on the administrative provision of long-term care services and are conducted for the Medicaid Advantage Plus and Partial Capitation managed care plans.

The review of Program of All-Inclusive Care for the Elderly managed care plan compliance with federal Medicaid standards is conducted and reported on by the Centers for Medicare & Medicaid Services¹⁰. A description of the Centers for Medicare & Medicaid Services’ review of this program, including objectives, technical methods of data collection and analysis, and corrective action plan process is in **Appendix A** of this report.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review, referenced in *Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii)*, to determine managed care compliance with federal Medicaid standards. To meet this federal regulation, the Department of Health provided IPRO with the most recent results of the Managed Care Operational Surveys and focused surveys conducted for the Medicaid Advantage Plus and Partial Capitation managed care plans.

The results of the operational surveys conducted in 2021 through 2023 for the Medicaid Advantage Plus and Partial Capitation managed care plans by the Department of Health and for the Program of All-Inclusive Care for the Elderly managed care plans by the Centers for Medicare & Medicaid Services are presented in this report, as well as the focused surveys conducted in 2023. The results of the compliance activities conducted in 2021 and 2022 are included in this report for a three year look back.

¹⁰ As Program of All-Inclusive Care for the Elderly plans are partially funded by Medicare, the Centers for Medicare & Medicaid Services maintain oversight of this activity.

Technical Methods of Data Collection and Analysis

Managed Care Operational Survey

The Department of Health's primary method for Managed Long-Term Care plan assessment and determination of compliance with federal and state Medicaid requirements is the Managed Care Operational Survey. The Managed Care Operational Survey is conducted by the Department of Health on a continuous timeline. Over time, the Department of Health's Operational Survey cycle has been stretched to accommodate the growing number of Managed Long-Term Care plans in the state. The Operational Survey is comprised of two parts: the Comprehensive Operational Survey and the Care Management Enrollee Record Review.

The Comprehensive Operational Survey is a full review of state and federal Medicaid requirements which cover the following:

- Organization and Management
- Service Delivery
- Fraud, Waste, Abuse, and Program Integrity
- Management Information Systems
- Medicaid Contract
- Member Services
- Utilization Review Management
- Complaints and Grievances, Non-Utilization Review
- Behavioral Health Services
- Person Centered Care Management
- Quality Initiatives, Quality Assurance, Quality Improvement
- Reporting
- Board of Directors
- Marketing Materials
- Enrollment Materials
- Provider Contracting and Credentialing
- Provider Oversight Reviews
- Personnel Review
- Uniform Assessment System for New York Management and Utilization Review
- Technical Assistance Center Compliance
- An evaluation of any previous Department of Health–approved corrective action plan to ensure that the plan has been implemented and that the noncompliance identified during the previous survey has been corrected.
- If the Managed Long-Term Care plan was subject to complaints, was found to be deficient as a result of other Department of Health monitoring activities, or has undergone operational changes during the past year, a review of these areas is conducted.

The Care Management Enrollee Record Review is a large component of the Managed Long-Term Care Operational Survey and includes the following:

- An evaluation of the Managed Long-Term Care plan's provision of services as it relates to enrollee safety, adequacy of care, utilization, and regulatory compliance.
- Comprehensive review of care management notes, assessments, and enrollee contacts spanning a multiple-month timeframe on a substantial enrollee sample size.

- Review of all action notices issued to all sampled enrollees during the survey review period, including, but not limited to, complaints, grievances and appeals termination/suspension/reduction, initial adverse determinations, service requests, and fair hearings.
- Eligibility review of enrolled members and a review of Medicaid recipients the Managed Long-Term Care plan found ineligible for enrollment.
- Person-centered service plans and person-centered care management.

Each Comprehensive Operational Survey was conducted in three phases:

Phase 1 - Comprehensive Operational Review

The survey team lead, or facilitator, completed a review of the Managed Long-Term Care plan's previous Managed Care Operational Survey results, as well as complaints history, external quality review activity results, and fair hearing data in preparation for the operational survey.

The Comprehensive Operational Survey commenced with the issuance of an announcement letter to the Managed Long-Term Care plan, along with a request for pertinent documents and data reports to serve as evidence of Managed Long-Term Care plan compliance with the Medicaid standards under review. The requested documents included, but were not limited to, organizational structure, policies and procedures, contracts and credentialing, utilization management and care management data, complaints, and grievances data.

Upon receipt of the requested documentation, the Department of Health survey team reviewed the documentation for evidence of Managed Long-Term Care plan compliance and to identify areas needing further review. The survey team utilized Department of Health-developed tools throughout the survey process to ensure that standardization of the evaluation of evidence for compliance was maintained.

Phase 2 - Care Management Enrollee Record Review

Enrollee records were requested from the Managed Long-Term Care plan to include all care management activities, contact notes, assessments, correspondence, and action and appeal notices from the period under review. The enrollee record review was done as a desk audit, and a sample of records was pulled after being identified for different specific issues. After the initial review was conducted, reliability and consistency checks were completed by the Department of Health survey team, and all reviewed records were combined and analyzed for deficiencies.

Phase 3 - Survey Wrap-up

Once the review of all files had been completed, a survey interview was held with all relevant Managed Long-Term Care plan staff, the Department of Health survey team, and any other necessary Department of Health staff. The Managed Long-Term Care plan was questioned on all discrepancies and deficiencies identified during the survey review and afforded the opportunity to respond to the findings and provide additional documentation, if desired. Once any additional documentation and Managed Long-Term Care plan responses/clarifications were reviewed, a statement of deficiency detailing the survey results was issued to the Managed Long-Term Care plan. For areas of non-compliance, the Managed Long-Term Care plan was required to submit a corrective action plan within 15 days to the Department of Health for approval. Once the corrective action plan was approved, the survey was considered closed.

IPRO cross walked the results of the operational and focused survey activities to Medicaid standards contained in *Title 42 Code of Federal Regulations 438*. The scope of these standards included in IPRO's crosswalk and in this report are:

- 438.56 Disenrollment requirements and limitations,
- 438.100 Enrollee rights requirements,
- 438.114 Emergency and poststabilization services,
- 438.206 Availability of services,
- 438.207 Assurances of adequate capacity and services,
- 438.208 Coordination and continuity of care,
- 438.210 Coverage and authorization of services,
- 438.214 Provider selection,
- 438.224 Confidentiality,
- 438.228 Grievance and appeal systems,
- 438.230 Subcontractual relationships and delegation,
- 438.236 Practice guidelines,
- 438.242 Health information systems, and
- 438.330 Quality assessment and performance improvement program.

Focused Surveys

Provider Network Data Systems Survey

In 2023, the Department of Health conducted a focused survey of all Program of All-Inclusive Care for the Elderly and Partial Capitation Plans for Quarter 1 of 2023 to ensure provider network adequacy. This focused survey assesses compliance with *Title 42 Code of Federal Regulations 438.206*.

The plans were required to submit provider network data each quarter to the Department of Health utilizing the Provider Network Database System Portal, along with any desired comments. Upon submission, the Provider Network Database System Portal generated a deficiency report, which was reviewed by the Department of Health for any potential system reporting errors, which were sent to each Plan providing them ten business days to add comments into the Provider Network Database System Portal under each deficiency to dispute any of the findings.

The Department of Health reviewed the comments and determined whether any of the identified deficiencies could be resolved and removed from the deficiency report. If the Plan did not add comments in the portal within ten business days, the deficiencies remained.

When the Department's review of the first quarter of 2023 was complete, the portal generated and sent the Final Report (Statement of Agreement) to each plan, which was signed by the plan's President or Chief Executive Officer and sent back to the Department of Health within five business days. Upon receipt, the Department of Health reviewed the signed report to determine whether a Statement of Deficiencies (SOD) was warranted based on the number of providers, per service type and county, a plan had contracted within their network listed in their report. All reviewed data was utilized to document plan compliance or the lack thereof.

Other Focused Surveys

In 2023 the Department of Health conducted numerous Focused Surveys on individual Managed Long-Term Care Health Plans that focused on specific topics identified as trending issues. These surveys included:

- ArchCare: Program of All-Inclusive Care for the Elderly Performance Improvement Project Focused Survey (assesses compliance with *Title 42 Code of Federal Regulations 438.330*);
- Elderplan: Partial Capitation Social Day Care Reduction Focused Survey (assesses compliance with *Title 42 Code of Federal Regulations 438.100 and 438.210*); and

- Fallon Health: Program of All-Inclusive Care for the Elderly Performance Improvement Project Focused Survey (assesses compliance with *Title 42 Code of Federal Regulations 438.330*).

Upon review of all requested information and data and the completion of the report, the areas of non-compliance were documented in Statements of Deficiencies. The Statements of Deficiencies outlined each deficiency identified, along with the specific MLTC contract, Federal and/or State regulation that specified the plan's requirements and, if applicable, a summary of the applicable plan policy, procedure, or process as well as whether the policy, procedure or process was not followed or required updating. The plan developed a Corrective Action Plan to come into compliance which included updates to the plan's policies, procedures and/or processes, a plan for ongoing monitoring, as well as conducting staff training, as necessary.

Description of Data Obtained

Managed Care Operational Survey

To evaluate Managed Long-Term Care plan compliance with federal and state Medicaid standards, IPRO reviewed the Department of Health-produced *Operational Deficiencies by Plan/Category Report* and the *Operational Plan Deficiencies Report*. The *Operational Deficiencies by Plan/Category Report* included a summary of noncompliance by review area for each Managed Long-Term Care plan, while the *Operational Plan Deficiencies Report* included detailed information on the areas of noncompliance for each Managed Long-Term Care plan. Both reports reflected the date of when the results were issued by the Department of Health to the Managed Long-Term Care plan, the corrective action plan submission date, and the corrective action plan approval date.

Focused Surveys

IPRO obtained focused survey methodology descriptions and results from the Department of Health.

The *Provider Network Data System Survey Methodology* document described the review period, eligibility criteria, data collection and analysis approach, and the framework for issuing statement of deficiencies to the Managed Long-Term Care plans. Surveys were shared with IPRO in Managed Long-Term Care plan-specific reports. Each report included the name of the Managed Long-Term Care plan, survey date, applicable state laws and regulations, and rationale for issued deficiencies.

The *Performance Improvement Project Survey Methodology* document described the criteria for review and determination of a Performance Improvement Project that was not compliant with the New York State Department of Health's standards. Each report included the name of the Managed Long-Term Care plan, survey date, applicable state laws and regulations, and rationale for issued deficiencies.

The *Social Day Care Reduction Survey Methodology* document described the data collection and analysis approach, and the framework for issuing statement of deficiencies to the Managed Long-Term Care plans. Surveys were shared with IPRO in Managed Long-Term Care plan-specific reports. Each report included the name of the Managed Long-Term Care plan, survey date, applicable state laws and regulations, and rationale for issued deficiencies.

Comparative Results

Managed Care Operational Survey

When available, Managed Long-Term Care plan results for the Operational Survey activities are presented by federal Medicaid standards in **Table 19**, **Table 20**, and **Table 21**. In these tables, a “C” indicates that the Managed Long-Term Care plan was in compliance with all standard requirements and an “NC” indicates that the Managed Long-Term Care plan was not in compliance with at least one standard requirement. The details for each “NC” designation are presented in the **Managed Long-Term Care Plan-Level Reporting** section of this report.

Table 19: Medicaid Advantage Plus Managed Care Plan Compliance Survey Results

Medicaid Advantage Plus	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
AgeWell ¹	Not Yet Scheduled	2019-2023														
Centers Plan	Not Yet Scheduled	2019-2023														
Elderplan	Not Yet Scheduled	2019-2023														
Empire BCBS HealthPlus	Not Yet Scheduled	2019-2023														
Fidelis Care	Not Yet Scheduled	2019-2023														
Hamaspik	Not Yet Scheduled	2019-2023														
MetroPlus	Not Yet Scheduled	2019-2023														
MHI Healthfirst	Not Yet Scheduled	2019-2023														
RiverSpring	Not Yet Scheduled	2019-2023														
Senior Whole Health	Not Yet Scheduled	2019-2023														
VillageCare	Not Yet Scheduled	2019-2023														
VNS Health	Not Yet Scheduled	2019-2023														

¹ AgeWell Medicaid Advantage Plus announced a withdrawal effective 12/31/2023.

Table 20: Partial Capitation Managed Care Plan Compliance Survey Results

Partial Capitation	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Aetna	Comprehensive	2020-2021	NC	C	C	C	C	NC	NC	NC	C	C	C	C	NC	C
	Focused Survey ¹	2023				NC										
ArchCare	Comprehensive	2019-2020	C	C	C	C	C	NC	NC	NC	C	NC	NC	C	NC	C
	Focused Survey ¹	2023				NC										
Centers Plan	Comprehensive	2020-2021	C	C	C	C	C	C	C	NC	C	NC	C	C	NC	C
	Focused Survey ¹	2023				NC										
Elderplan	Not Yet Scheduled	2019-2022														
	Comprehensive	2023	C	C	C	C	C	NC	NC	C	C	C	C	C	C	C
	Focused Survey ¹	2023				NC										
	Focused Survey ²	2023		NC					NC							
Elderwood	Not Yet Scheduled	2019-2022														
	Comprehensive	2023	C	C	C	NC	C	NC	NC	C	C	C	C	C	NC	C
	Focused Survey ¹	2023				NC										
Empire BCBS HealthPlus	Not Yet Scheduled	2019-2022														
	Comprehensive Survey Initiated and In Progress	2023														
	Focused Survey ¹	2023				C										

Partial Capitation	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
EverCare	Comprehensive	2021-2022	C	NC	C	C	C	NC	NC	C	C	C	C	C	NC	C
	Focused Survey ¹	2023				NC										
Extended MLTC ³	Not Yet Scheduled	2019-2022														
	Focused Survey ¹	2023				NC										
Fallon Health	Comprehensive	2021-2022	C	C	C	NC	C	NC	NC	NC	C	C	C	C	NC	C
	Focused Survey ¹	2023				C										
Fidelis Care	Not Yet Scheduled	2019-2022														
	Focused Survey ¹	2023				NC										
Hamaspik	Not Yet Scheduled	2019-2022														
	Comprehensive Survey Initiated and In Progress	2023														
	Focused Survey ¹	2023				NC										
iCircle	Comprehensive	2019-2020	C	C	C	NC	C	NC	NC	NC	C	NC	NC	C	NC	C
	Focused Survey ¹	2023				NC										
Kalos Health	Comprehensive	2021-2022	C	C	C	NC	C	NC	NC	NC	C	C	C	C	NC	C
	Focused Survey ¹	2023				NC										

Partial Capitation	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
MetroPlus	Not Yet Scheduled	2019-2022														
	Comprehensive	2023	NC	C	C	C	C	NC	C	C	C	NC	C	C	NC	C
	Focused Survey ¹	2023				C										
Montefiore ⁴	Not Yet Scheduled	2019-2022														
	Comprehensive	2023	C	C	C	C	C	NC	C	NC	C	C	NC	C	NC	C
	Focused Survey ¹	2023				C										
Nascentia	Comprehensive	2020-2021	C	C	C	NC	C	NC	NC	C	C	C	C	C	C	C
	Focused Survey ¹	2023				NC										
Prime Health	Not Yet Scheduled	2019-2022														
	Comprehensive	2023	C	C	C	NC	C	NC	NC	NC	C	NC	NC	C	C	C
	Focused Survey ¹	2023				NC										
RiverSpring	Comprehensive	2020-2021	C	C	C	C	C	NC	NC	C	C	C	C	C	NC	C
	Focused Survey ¹	2023				NC										
Senior Health Partners	Not Yet Scheduled	2019-2022														
	Focused Survey ¹	2023				NC										

Partial Capitation	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Senior Network Health	Comprehensive	2020-2021	C	C	C	NC	C	NC	NC	NC	C	C	NC	C	C	C
	Focused Survey ¹	2023				NC										
Senior Whole Health	Comprehensive	2019-2020	C	C	C	C	C	NC	NC	NC	C	NC	NC	C	NC	C
	Focused Survey ¹	2023				NC										
VillageCare	Not Yet Scheduled	2019-2022														
	Comprehensive	2023	C	C	C	C	C	NC	C	C	C	NC	C	C	C	C
	Focused Survey ¹	2023				C										
VNS Health	Comprehensive	2020-2021	C	C	C	NC	C	NC	C	NC	C	C	NC	C	NC	C
	Focused Survey ¹	2023				NC										

¹ Provider Network Delivery System Focused Survey.

² Social Day Care Reduction Focused Survey.

³ Extended MLTC was acquired by Hamaspik on 8/1/2023.

⁴ Montefiore was acquired by RiverSpring on 12/31/2023.

C: Managed Long-Term Care plan is in compliance with all standard requirements; NC: Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 21: Program of All-Inclusive Care for the Elderly Managed Care Plan Compliance Survey Results

Program of All-Inclusive Care for the Elderly	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
ArchCare	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	Focused Survey ³	2023														NC
Catholic Health	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
CenterLight	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
Complete Senior Care	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
Eddy SeniorCare	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
ElderONE	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
Fallon Health	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				C										
	Focused Survey ³	2023														NC
PACE CNY	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				C										

Program of All-Inclusive Care for the Elderly	Activity	Results Issued	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Total Senior Care	No Activity ¹	2021														
	No Activity ¹	2022														
	Focused Survey ²	2023				NC										

¹ No activity scheduled by the Centers for Medicare & Medicaid Services for the Program of All-Inclusive Care for the Elderly plans due to COVID-19.

² Provider Network Delivery System Focused Survey.

³ Performance Improvement Project Focused Survey.

External Quality Review Activity 4. Validation of Network Adequacy

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

States must set rules for the availability of certain types of providers and services, and the time and distance patients can travel to seek services. New York State has rules that match the federal rules for Medicaid. The New York State Department of Health makes sure that managed care plans follow these rules. These rules are part of contracts and laws in New York, making sure that managed care plans provide complete service access in all areas. Managed care plans must cover all health services listed in the approved benefit package. Networks for Medicaid plans are also checked for each county. Federal regulations require that state agencies must hire an external quality review organization to check network adequacy each year.

In 2023, all Managed Long-Term Care Partial Capitation, Medicaid Advantage Plus, and Program of All-Inclusive Care Plans were reviewed to ensure their networks met the standards.

2023 Network Adequacy Summary

Validation Process

- Do managed care plan provider networks follow the state's laws?
- Do provider networks meet time and distance standards?
- Do provider networks include the required amount of each provider per county?

Validation Results

- IPRO validated the network adequacy of all managed care plans.
- All managed care plans passed validation.
- All managed care plans met validation requirements to report network adequacy to New York State.

Network Adequacy Results

- All managed care plans met the federal standards for network adequacy.
- Three managed care plans had no gaps identified in the state standards for network adequacy in Quarter 4, 2023.
- All managed care plans submitted a statement of agreement allowing members in counties not meeting the state standards for network adequacy to access providers out of network.

For more information about validation of network adequacy, please read the rest of this section.

Technical Summary – Validation of Network Adequacy

Objectives

Title 42 Code of Federal Regulations Sections 438.68 Network adequacy standards require states that contract with a managed care plan to develop and enforce network adequacy standards based on how many individuals are enrolled and the health and service care needs of those enrolled; how many medical providers are available to serve those individuals, and the location of those providers; are there Medicaid or public transportation services available that members could use for visits to those providers; are there providers who understand the various cultures that they serve and are they able to speak with members in their language; can providers serve patients that are in need of special assistance with entering, moving about, using medical equipment, and leaving the facility; do providers have telemedicine, e-visits or electronic access services available; and how long does it take to receive an appointment for a routine visit. These standards apply to the following provider types: adult and pediatric primary care, obstetrics/gynecology, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and supports.

The State of New York codified Managed Long-Term Care access standards that align with these federal requirements, and identified additional state-specific standards. The Department of Health enforces managed care plan adoption of these standards in the *Medicaid Managed Long-Term Care Partial Capitation Model Contract*, the *Medicaid Advantage Plus Model Contract*, the *Program of All-Inclusive Care for the Elderly Model Contract*, *New York State Public Health Law Article 44*, and *Title 10 of the New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*.

The Department of Health's standards and guidelines for service delivery networks ensure that managed care plans maintain a high standard of service delivery across programs and regions, and are able to provide or arrange for the full range of comprehensive health services covered in the approved benefit package to enrollees. Service delivery networks for Managed Long-Term Care Partial Capitation, Medicaid Advantage Plus, and Program of All-Inclusive Care for the Elderly plans are reviewed on a county-specific basis quarterly and may encompass primary care, specialty care, ancillary providers, and related institutions.

Table 22: , **Table 23**, and **Table 24** display the Department of Health’s travel time standards, and **Table 25**, **Table 26**, and

Table 27 display the Department of Health’s service delivery network standards. The *2022-2026 Partial Capitation Model Contract section D Network Requirements of Covered Services*, *2022-2026 Medicaid Advantage Plus Model Contract section 15.5 Travel Time Standards*, and *42 Code of Federal Regulations Part 460 (e) PACE Center Operation* displayed in **Table 25**, **Table 26**, and

Table 27 were applicable to Managed Long-Term Care Partial Capitation Plans, Medicaid Advantage Plus Plans, and Program of All-Inclusive Care for the Elderly Plans except where noted.

Table 22: New York Managed Long-Term Care Medicaid Advantage Plus Travel Time Standards for Managed Care Plans

New York Travel Time Standards for Managed Long-Term Care Medicaid Advantage Plus Plans	
Geographic Area	Travel Time Standards ¹
Urban, Suburban	Thirty (30) minutes or thirty miles from enrollee residence
Rural	May be greater than thirty (30) minutes or thirty (30) miles from enrollee residence if based on the community standard for accessing care or if by enrollee choice

¹ Travel time standards are measured from the member’s residence to an available participating provider.

Table 23: New York Managed Long-Term Care Partial Capitation Travel Time Standards for Managed Care Plans

New York Travel Time Standards for Managed Long-Term Care Partial Capitation Plans	
Geographic Area	Travel Time Standards ¹
Metropolitan	Thirty (30) minutes from enrollee residence
Non-metropolitan	Thirty (30) miles from enrollee residence
Rural	Transportation requirements may exceed these standards if justified based on the availability of providers within the non-metropolitan 30 minute/mile standard

¹ Travel time standards are measured from the member’s residence to an available participating provider.

Table 24: New York Managed Long-Term Care Program of All-Inclusive Care for the Elderly Travel Time Standards for Managed Care Plans

New York Travel Time Standards for Managed Long-Term Care Program of All-Inclusive Care for the Elderly Plans	
Geographic Area	Travel Time Standards ¹
Metropolitan	Thirty (30) minutes by public transportation from enrollee residence
Non-metropolitan	Thirty (30) minutes or miles by public transportation or by car from enrollee residence
Rural	Transportation requirements may exceed these standards if justified based on the availability of providers within the non-metropolitan 30 minute/mile standard

¹ Travel time standards are measured from the member’s residence to an available participating provider.

Table 25: New York Service Delivery Network Standards for Partial Capitation Managed Long-Term Care Plans

New York Managed Long-Term Care Partial Capitation Service Delivery Network Standards		
Service Type	Service Specification	Service Delivery Network Standard Per County ¹
Adult Day Health Care	Facility	Minimum of two (2) per county statewide ¹
Assistive Technology Agency and Adaptive Technology	Facility	Minimum of two (2) per county statewide ¹
Audiology Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Certified Home Health	Facility	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Medical Social Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹

New York Managed Long-Term Care Partial Capitation Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
Certified Home Health: Home Based Occupational Therapy	Facility	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Physical Therapy	Facility	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Speech Therapy	Facility	Minimum of two (2) per county statewide ¹
Certified or Licensed Home Health Care- Personal Care Assistant	Facility	Minimum of two (2) per county statewide ¹
Community Transitional Service	Facility	Minimum of two (2) per county statewide ¹
Durable Medical Equipment	Facility	Minimum of two (2) per county statewide ¹
Environmental Modifications	Facility	Minimum of two (2) per county statewide ¹
Fiscal Intermediary	Facility	Minimum of two (2) per county statewide ¹
General Dentistry	Provider	Minimum of two (2) per county statewide ¹
Home and Community Support Services	Facility	Minimum of two (2) per county statewide ¹
Home Delivered and Congregate Meals	Facility	Minimum of two (2) per county statewide ¹
Institutional Long-Term Care	Facility	Minimum of two (2) per county statewide ¹
Institutional Long-Term Care (AIDS Skilled Nursing Facility)	Facility	Minimum of two (2) per county statewide ¹
Institutional Long-Term Care (Vent Skilled Nursing Facility)	Facility	Minimum of two (2) per county statewide ¹
Institutional Short-Term Care	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Medical Social Services	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Occupational Therapy	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Physical Therapy	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Speech Therapy	Facility	Minimum of two (2) per county statewide ¹
Moving Assistance	Facility	Minimum of two (2) per county statewide ¹
Non- Emergent Transportation	Facility	Minimum of two (2) per county statewide ¹
Nutrition	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Optometry	Provider	Minimum of two (2) per county statewide ¹
Oral Surgery	Provider	Minimum of two (2) per county statewide ¹
Personal Emergency Response	Facility	Minimum of two (2) per county statewide ¹
Podiatry	Provider	Minimum of two (2) per county statewide ¹
Private Duty Nursing	Facility	Minimum of two (2) per county statewide ¹
Social and Environmental Support	Facility	Minimum of two (2) per county statewide ¹
Social Day Care	Facility	Minimum of two (2) per county statewide ¹

New York Managed Long-Term Care Partial Capitation Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
Telehealth	Facility	Minimum of two (2) per county statewide ¹
Therapy: Occupational	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Physical	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Respiratory	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Speech and Language	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Vehicle Modification	Facility	Minimum of two (2) per county statewide ¹

¹ A minimum of two providers, per service type, per county is the threshold. However, this can vary based on plan enrollment and Department requirements.

Table 26: New York Service Delivery Network Standards for Medicaid Advantage Plus Plans

New York Medicaid Advantage Plus Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
Adult Day Health Care	Facility	Minimum of two (2) per county statewide ¹
Assertive Community Treatment	Facility	Minimum of two (2) per county statewide ¹
Assistive Technology Agency and Adaptive Technology	Facility	Minimum of two (2) per county statewide ¹
Audiology Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Certified Home Health	Facility	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Medical Social Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Occupational Therapy	Facility	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Physical Therapy	Facility	Minimum of two (2) per county statewide ¹
Certified Home Health: Home Based Speech Therapy	Facility	Minimum of two (2) per county statewide ¹
Certified or Licensed Home Health Care- Personal Care Assistant	Facility	Minimum of two (2) per county statewide ¹
Community Transitional Service	Facility	Minimum of two (2) per county statewide ¹
Comprehensive Psychiatric Emergency Program	Facility	Minimum of two (2) per county statewide ¹
Core Community Psychiatric Supports and Treatment	Facility	Minimum of two (2) per county statewide ¹
Core Family Support and Training	Facility	Minimum of two (2) per county statewide ¹
Core Peer Support	Facility	Minimum of two (2) per county statewide ¹
Core Psychosocial Rehabilitation	Facility	Minimum of two (2) per county statewide ¹
Durable Medical Equipment	Facility	Minimum of two (2) per county statewide ¹
Environmental Modifications	Facility	Minimum of two (2) per county statewide ¹
Fiscal Intermediary	Facility	Minimum of two (2) per county statewide ¹
General Dentistry	Provider	Minimum of two (2) per county statewide ¹

New York Medicaid Advantage Plus Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
Home and Community Support Services	Facility	Minimum of two (2) per county statewide ¹
Home Delivered and Congregate Meals	Facility	Minimum of two (2) per county statewide ¹
Inpatient Chemical Dependency	Facility	Minimum of two (2) per county statewide ¹
Inpatient Mental Health	Facility	Minimum of two (2) per county statewide ¹
Institutional Long Term Care	Facility	Minimum of two (2) per county statewide ¹
Institutional Long Term Care (AIDS Skilled Nursing Facility)	Facility	Minimum of two (2) per county statewide ¹
Institutional Long Term Care (Vent Skilled Nursing Facility)	Facility	Minimum of two (2) per county statewide ¹
Institutional Short Term Care	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Medical Social Services	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Occupational Therapy	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Physical Therapy	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Speech Therapy	Facility	Minimum of two (2) per county statewide ¹
Medically Managed Detox Services	Facility	Minimum of two (2) per county statewide ¹
Medically Supervised Detox Services- Inpatient	Facility	Minimum of two (2) per county statewide ¹
Medically Supervised Detox Services- Outpatient	Facility	Minimum of two (2) per county statewide ¹
Moving Assistance	Facility	Minimum of two (2) per county statewide ¹
Non- Emergent Transportation	Facility	Minimum of two (2) per county statewide ¹
Nutrition	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Opioid Treatment Program	Facility	Minimum of two (2) per county statewide ¹
Optometry	Provider	Minimum of two (2) per county statewide ¹
Oral Surgery	Provider	Minimum of two (2) per county statewide ¹
Outpatient Chemical Dependency- Clinic	Facility	Minimum of two (2) per county statewide ¹
Outpatient Chemical Dependency- Outpatient Rehabilitation	Facility	Minimum of two (2) per county statewide ¹
Outpatient Mental Health Clinic	Facility	Minimum of two (2) per county statewide ¹
Outpatient Mental Health Clinic- State Operated	Facility	Minimum of two (2) per county statewide ¹
Partial Hospitalization	Facility	Minimum of two (2) per county statewide ¹
Personal Emergency Response	Facility	Minimum of two (2) per county statewide ¹

New York Medicaid Advantage Plus Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
Personalized Recovery Oriented Services, Continuing Day Treatment	Facility	Minimum of two (2) per county statewide ¹
Podiatry	Provider	Minimum of two (2) per county statewide ¹
Private Duty Nursing	Facility	Minimum of two (2) per county statewide ¹
Residential Substance Abuse Treatment Services	Facility	Minimum of two (2) per county statewide ¹
Social and Environmental Support	Facility	Minimum of two (2) per county statewide ¹
Social Day Care	Facility	Minimum of two (2) per county statewide ¹
Telehealth	Facility	Minimum of two (2) per county statewide ¹
Therapy: Occupational	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Physical	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Respiratory	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Speech and Language	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Vehicle Modification	Facility	Minimum of two (2) per county statewide ¹

¹ A minimum of two providers, per service type, per county is the threshold. However, this can vary based on plan enrollment and Department requirements.

Table 27: New York Service Delivery Network Standards for Program of All-Inclusive Care for the Elderly Plans

New York Program of All-Inclusive Care for the Elderly Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
Adult Day Health Care	Facility	Minimum of two (2) per county statewide ¹
Anesthesiology Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Assistive Technology Agency and Adaptive Technology	Facility	Minimum of two (2) per county statewide ¹
Audiology Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Cardiology	Provider	Minimum of two (2) per county statewide ¹
Certified Home Health	Facility	Minimum of two (2) per county statewide ¹
Certified or Licensed Home Health Care- Personal Care Assistant	Facility	Minimum of two (2) per county statewide ¹
Clinical Psychology, Psychology	Provider	Minimum of two (2) per county statewide ¹
Community Transitional Service	Facility	Minimum of two (2) per county statewide ¹
Consumer Directed Personal Care	Facility	Minimum of two (2) per county statewide ¹
Dermatology	Provider	Minimum of two (2) per county statewide ¹
Durable Medical Equipment	Facility	Minimum of two (2) per county statewide ¹
Endocrinology and Metabolism	Provider	Minimum of two (2) per county statewide ¹
Environmental Modifications	Facility	Minimum of two (2) per county statewide ¹
Fiscal Intermediary	Facility	Minimum of two (2) per county statewide ¹
Gastroenterology	Provider	Minimum of two (2) per county statewide ¹
General Dentistry	Provider	Minimum of two (2) per county statewide ¹
General Surgery	Provider	Minimum of two (2) per county statewide ¹

New York Program of All-Inclusive Care for the Elderly Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County ¹
Geriatrics	Provider	Minimum of two (2) per county statewide ¹
Gynecology	Provider	Minimum of two (2) per county statewide ¹
Home and Community Support Services	Facility	Minimum of two (2) per county statewide ¹
Home Delivered and Congregate Meals	Facility	Minimum of two (2) per county statewide ¹
Inpatient Hospital (Medical Inpatient)	Facility	Minimum of two (2) per county statewide ¹
Institutional Long Term Care	Facility	Minimum of two (2) per county statewide ¹
Institutional Long Term Care (AIDS Skilled Nursing Facility)	Facility	Minimum of two (2) per county statewide ¹
Institutional Long Term Care (Vent Skilled Nursing Facility)	Facility	Minimum of two (2) per county statewide ¹
Institutional Short Term Care	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Medical Social Services	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Occupational Therapy	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Physical Therapy	Facility	Minimum of two (2) per county statewide ¹
Licensed Home Health Care: Home Based Speech Therapy	Facility	Minimum of two (2) per county statewide ¹
Medical Laboratories	Facility	Minimum of two (2) per county statewide ¹
Moving Assistance	Facility	Minimum of two (2) per county statewide ¹
Nephrology	Provider	Minimum of two (2) per county statewide ¹
Neurology	Provider	Minimum of two (2) per county statewide ¹
Neurology Surgery	Provider	Minimum of two (2) per county statewide ¹
Non- Emergent Transportation	Facility	Minimum of two (2) per county statewide ¹
Nutrition	Provider and/or Facility	Minimum of two (2) per county statewide ¹
Oncology and Hematology	Provider	Minimum of two (2) per county statewide ¹
Ophthalmology	Provider	Minimum of two (2) per county statewide ¹
Optometry	Provider	Minimum of two (2) per county statewide ¹
Oral Surgery	Provider	Minimum of two (2) per county statewide ¹
Orthopedics	Provider	Minimum of two (2) per county statewide ¹
Otolaryngology	Provider	Minimum of two (2) per county statewide ¹
Personal Emergency Response	Facility	Minimum of two (2) per county statewide ¹
Pharmacy	Facility	Minimum of two (2) per county statewide ¹
Physical Medicine and Rehabilitation	Provider	Minimum of two (2) per county statewide ¹
Plastic Surgery	Provider	Minimum of two (2) per county statewide ¹
Podiatry	Provider	Minimum of two (2) per county statewide ¹

New York Program of All-Inclusive Care for the Elderly Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County ¹
Primary Care Providers	Provider	Minimum of two (2) per county statewide ¹
Private Duty Nursing	Facility	Minimum of two (2) per county statewide ¹
Psychiatry	Provider	Minimum of two (2) per county statewide ¹
Pulmonary Medicine	Provider	Minimum of two (2) per county statewide ¹
Radiology	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Rheumatology	Provider	Minimum of two (2) per county statewide ¹
Social and Environmental Support	Facility	Minimum of two (2) per county statewide ¹
Social Day Care	Facility	Minimum of two (2) per county statewide ¹
Telehealth	Facility	Minimum of two (2) per county statewide ¹
Therapy: Occupational	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Physical	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Respiratory	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Therapy: Speech and Language	Facility and/or Provider	Minimum of two (2) per county statewide ¹
Thoracic Surgery	Provider	Minimum of two (2) per county statewide ¹
Transportation (Ambulance Service)	Facility	Minimum of two (2) per county statewide ¹
Urology	Provider	Minimum of two (2) per county statewide ¹
Vehicle Modification	Facility	Minimum of two (2) per county statewide ¹

¹ A minimum of two providers, per service type, per county is the threshold. However, this can vary based on plan enrollment and Department requirements.

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review, Title 42 Code of Federal Regulations Section 457.1250 External quality review, Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review, and Protocol 4. Validation of Network Adequacy establish that state agencies must contract with an external quality review organization to perform the annual validation of network adequacy. Protocol 4. Validation of Network Adequacy permits state agencies to analyze network data submitted by managed care plans and for the external quality review organization to conduct the validation of network adequacy using the results of the state's analyses. The Department of Health contracted with IPRO to fulfill this requirement for measurement year 2023.

Technical Methods for Data Collection and Analysis

Data collection and analysis are conducted quarterly through the Provider Network Data System. This system captures data on provider types and geographic distribution. The data submitted to the Provider Network Data System by the managed care plans includes detailed information on the number and types of providers in each county.

The Department of Health's quarterly reviews include an evaluation of managed care plan provider networks across counties and regions. This evaluation assesses managed care plan network adequacy based on geographic accessibility. Each identified network gap is mapped to a gap type in

Table 28.

Table 28: Service Delivery Network Gap Types

New York Service Delivery Network Gap Types	
Type	Description
Not A Gap	Gap removed
County Access Gap	Zero providers contracted in a county where provider(s) are available
County Choice Gap	Insufficient number of providers contracted in a county where providers are available
Surrounding Area Access Gap	Zero providers contracted in a service area where provider(s) are available
Surrounding Area Choice Gap	Insufficient number of providers contracted in a service area where providers are available
No Gap	No providers available to contract

Gaps are summarized for each managed care plan and presented in a statement of agreement to the managed care plan’s chief executive officer. The statement of agreement includes provisions that allow members impacted by a gap to access care outside of the managed care plan’s network. A statement of agreement must be signed by the managed care plan’s chief executive officer within 10 business days of receipt.

Description of Data Received

For the 2023 external quality review period, the Department of Health provided IPRO with copies of the *Medicaid Managed Long-Term Care Partial Capitation Model Contract*, the *Medicaid Advantage Plus Model Contract*, the *Program of All-Inclusive Care for the Elderly Model Contract* and *PNDS Review Guidance*, as well as statement of agreements issued to the managed care plans following the Department of Health’s analyses of the 2023 fourth quarter submissions to the Provider Network Data System. Extended MLTC partial capitation plan was acquired by Hamaspik Choice partial capitation plan on 8/1/2023 and therefore did not have a fourth quarter network adequacy evaluation performed. The standards put in place by the Department of Health are in addition to the federal requirements. All Managed Long-Term Care Partial Capitation Plans, Medicaid Advantage Plus Plans, and Program of All-Inclusive Care for the Elderly Plans met the federal requirements for Network Adequacy.

The *Medicaid Managed Long-Term Care Partial Capitation Model Contract*, the *Medicaid Advantage Plus Model Contract*, the *Program of All-Inclusive Care for the Elderly Model Contract* includes an overview of core provider types and programs, as well as network requirements such as travel time standards, and the minimum number of providers required per county. The document also specifies the requirement for managed care plans to submit network data on a quarterly basis for evaluation by the Department of Health.

The *PNDS Review Guidance* document is internal to the Department of Health and it describes the review process for managed care plan network data submissions. The document also includes gap status and gap status types.

Each statement of agreement included the name of the managed care plan and program, quarterly reporting period, provisions for out-of-network coverage, network requirements to be met to address gaps, and a table displaying gaps by county and specialty or services. The document also included the name and dated signature of the managed care plan’s chief executive officer.

Comparative Results

Managed Long-Term Care plan results for the evaluation of Network Adequacy are presented in **Table 29**, **Table 30**, and **Table 31**. In these tables, “met” indicates that the plan had no gaps in their network, or a Statement of Agreement was established with the New York State Department of Health allowing members to receive services from out of network providers. Managed Care Plan-specific results are presented in the **Managed Long-Term Care Plan-Level Reporting** section of this report.

Table 29: Medicaid Advantage Plus Evaluation of Network Adequacy, Quarter 4, 2023

Managed Care Plan	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Medicaid Advantage Plus
AgeWell ¹	Pass	Met
Centers Plan	Pass	Met
Elderplan	Pass	Met
Empire BCBS HealthPlus	Pass	Met
Fidelis Care	Pass	Met
Hamaspik	Pass	Met
MetroPlus	Pass	Met
MHI Healthfirst	Pass	Met
RiverSpring	Pass	Met
Senior Whole Health	Pass	Met
VillageCare	Pass	Met
VNS Health	Pass	Met

Met means that the plan had no gaps in their network, or a Statement of Agreement was established with the New York State Department of Health allowing members to receive services from out of network providers.

¹ AgeWell Medicaid Advantage Plus had a withdrawal effective 12/31/2023.

Table 30: Partial Capitation Evaluation of Network Adequacy, Quarter 4, 2023

Managed Care Plan ¹	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Partial Capitation
Aetna	Pass	Met
ArchCare	Pass	Met
Centers Plan	Pass	Met
Elderplan	Pass	Met
Elderwood	Pass	Met
Empire BCBS HealthPlus	Pass	Met
EverCare	Pass	Met
Fallon Health	Pass	Met
Fidelis Care	Pass	Met
Hamaspik	Pass	Met
iCircle	Pass	Met
Kalos Health	Pass	Met
MetroPlus	Pass	Met
Montefiore ²	Pass	Met

Managed Care Plan ¹	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Partial Capitation
Nascentia	Pass	Met
Prime Health	Pass	Met
RiverSpring	Pass	Met
Senior Health Partners	Pass	Met
Senior Network Health	Pass	Met
Senior Whole Health	Pass	Met
VillageCare	Pass	Met
VNS Health	Pass	Met

Met means that the plan had no gaps in their network, or a Statement of Agreement was established with the New York State Department of Health allowing members to receive services from out of network providers.

¹ Extended MLTC Partial Capitation Plan ceased operations within measurement year 2023. Extended MLTC Partial Capitation Plan was acquired by Hamaspiik Choice Partial Capitation Plan on 8/1/2023.

² Montefiore Diamond Care Partial Capitation Plan was acquired by RiverSpring/ElderServe MLTC Partial Capitation Plan on 12/31/2023.

Table 31: Program of All-Inclusive Care for the Elderly Evaluation of Network Adequacy, Quarter 4, 2023

Managed Care Plan	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Program of All-Inclusive Care for the Elderly
ArchCare	Pass	Met
Catholic Health	Pass	Met
CenterLight	Pass	Met
Complete Senior Care	Pass	Met
Eddy Senior Care	Pass	Met
ElderONE	Pass	Met
Fallon Health	Pass	Met
PACE CNY	Pass	Met
Total Senior Care	Pass	Met

Met means that the plan had no gaps in their network, or a Statement of Agreement was established with the New York State Department of Health allowing members to receive services from out of network providers.

External Quality Review Activity 6. Administration of Quality-of-Care Survey

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Survey

Understanding the experiences that New Yorkers have with the Medicaid Managed Long-Term Care program is a priority for the Department of Health. IPRO administers a survey on behalf of the Department of Health every other year. The survey is sent to a random selection of New Yorkers that were enrolled in one of the Medicaid Managed Long-Term Care plans. The survey asks these New Yorkers to rate their experiences with Medicaid Managed Long-Term Care plans, health care services, personal doctors, and specialists. This survey is called the Member Satisfaction Survey. IPRO ensures that the survey is conducted properly and that the results are calculated correctly.

The Department of Health uses the survey results to monitor Medicaid Managed Long-Term Care plan and provider performance. The Medicaid Managed Long-Term Care plans use the survey results to understand the experience New Yorkers have with their plan. In 2023, IPRO surveyed adult New Yorkers who received care through a Medicaid Managed Long-Term Care plan.



For more information about the 2023 survey, please read the Technical Summary – Administration of Quality-of-Care Surveys section.

Technical Summary – Administration of Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations Section 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality-of-care may be performed by using information derived during the preceding 12 months. Further, *Title 42 Code of Federal Regulations Section 438.358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

The Department of Health sponsors a member experience survey every other year for members enrolled in a Medicaid managed long-term care plan. The goal of the survey is to obtain feedback from these members about how they view the health care services they receive. The Department of Health uses results from the survey to monitor member satisfaction among the Managed Long-Term Care plans.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the quality-of-care survey activity. To meet this federal regulation, the Department of Health contracted with IPRO to administer the 2023 Member Satisfaction Survey for the Managed Long-Term Care program.

This external quality review report presents the 2023 survey results for the Medicaid Advantage Plus, Program of All-Inclusive Care for the Elderly, and Partial Capitation plans.

Technical Methods of Data Collection and Analysis

In collaboration with the Department of Health, IPRO designed a scannable, three-part survey instrument:

- Part 1: *Your Managed Long-Term Care Plan*, addressed members' general experience with their Medicaid Managed Long-Term Care plan and included questions on plan of care involvement, courtesy of plan representatives, and timeliness of responses to complaints and grievances.
- Part 2: *Your Care Providers*, addressed the quality of 22 types of long-term care providers and services; these items asked members to rate the quality of these providers and services, whether covered by the members' plan or not. This section also addressed timeliness of some key long-term care services and access to health care services.
- Part 3: *About You*, contained general demographic questions, questions pertaining to living arrangements and whether assistance was provided in completing the survey, as well as questions regarding the status of members' advance directives.

Adults who were current members of a New York State Medicaid Managed Long-Term Care plan and who were continuously enrolled with the managed care plan for at least six months from March 2022 through August 2022 were eligible for the 2023 survey. A stratified random sample was drawn for each Managed Long-Term Care plan, resulting in a statewide sample size of 25,192 members. The entire eligible membership was included for Medicaid Managed Long-Term Care plans with an enrollment of less than 600.

Members were surveyed in English, Spanish, Russian, or Chinese. The survey was administered between March 2023 and August 2023 using a mail-only three-wave protocol.

Table 32 provides a summary of the technical methods of data collection.

Table 32: Medicaid Managed Long-Term Care 2023 Member Satisfaction Survey Data Collection Summary

Category	Data Collection Information
Survey Administrator	IPRO
Survey Tool	State-specific
Survey Timeframe	March 2023 to August 2023
Method of Collection	Mail only, three waves
Sample Size	21,592
Number of Completed Surveys	5,258
Response Rate	20.9%

IPRO computed composite scores using the proportional scoring method, representing the average proportion of members responding to the most positive categories, or top-box categories for the survey items included in the composite, excluding missing data. For example, for survey items requiring the responder to answer “Always,” “Usually,” “Sometimes,” or “Never,” the calculated score reflects the average proportion of responders who answered “Always/Usually.” For survey items requiring the responder to answer “Excellent,” “Good,” “Fair,” or “Poor,” the calculated score reflects the average proportion of responders who answered “Excellent/Good.”

IPRO applied a Z-test to compare proportions for single survey items year-to-year, and t-tests were used to compare average proportions for composite measures year-to-year.

When comparing within subgroups (i.e., plan type, race, gender, and educational attainment), chi-square tests were utilized to compare proportions of single survey items, and Student’s t-tests were utilized to compare average proportions for composite measures.

Where appropriate, the Department of Health risk-adjusted select Medicaid Managed Long-Term Care plan rates to reduce the effect of a managed care plan’s case-mix on the outcome. The Department of Health weighted statewide survey results to account for the differences in size across the Medicaid Managed Long-Term Care plans.

Description of Data Obtained

For the external quality review, the IPRO-produced *New York State Department of Health Managed Long-Term Care 2023 Member Satisfaction Survey Report*¹¹ and the Managed Long-Term Care performance dataset prepared by the Department of Health¹² were referenced. The IPRO-produced report included comprehensive descriptions of the project objectives, methodology, and data analysis, as well as results at the statewide and managed long-term care program-levels. The Managed Long-Term Care performance dataset prepared by the Department of Health was also referenced for the external quality review. The dataset included Managed Long-Term Care plan risk-adjusted member satisfaction results, as well as weighted statewide averages. The Department of Health’s dataset with risk-adjusted member satisfaction results is the source of the data presented in this report.

Comparative Results

Table 33 displays statewide Medicaid Managed Long-Term Care results for the *2023 Member Satisfaction Survey*.

¹¹https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_satisfaction_surveydi_summary_report_2023.pdf

¹²<https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp/data>

Table 33: Medicaid Managed Long-Term Care 2021-2023 Member Satisfaction Results

Measure	Measurement Year 2021	Measurement Year 2023
Rating of Health Plan	90%	82%
Rating of Dentist	73%	72%
Rating of Care Manager	88%	87%
Rating of Regular Visiting Nurse	85%	84%
Rating of Home Health Aide	94%	93%
Rating of Transportation Services	78%	72%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	84%	85%
Involved in Decisions	83%	84%
Manage Illness	86%	85%
Access to Routine Dental Care	35%	35%
Same Day Urgent Dental Care	27%	26%
Plan Asked to See Medicines	93%	93%
Talked About Appointing for Health Decisions	77%	74%
Document Appointing for Health Decisions	63%	61%
Plan Has Document Appointing for Health Decisions	83%	85%

Note: Rates reported above are statewide risk-adjusted rates publicly reported on Health Data New York [Managed Long-Term Care Performance Data: Beginning 2014 | State of New York \(ny.gov\)](https://www.healthdata.ny.gov/managed-long-term-care-performance-data-beginning-2014) .

Managed Long-Term Care Plan-Level Reporting

To assess the impact of Managed Long-Term Care on the quality of, timeliness of, and access to health care services, IPRO considered managed care plan responses to the 2022 external quality review recommendations, as well as plan-level results from the external quality review activities. Specifically, IPRO considered the following elements during the 2023 external quality review:

- Managed Long-Term Care Plan Follow-up on 2022 External Quality Review Recommendations
- External Quality Review Mandatory Activity 1. Performance Improvement Projects, 2023
- External Quality Review Mandatory Activity 2. Performance Measures, 2023
- External Quality Review Mandatory Activity 3. Compliance with Medicaid and Children’s Health Insurance Program Standards, 2021-2023
- External Quality Review Mandatory Activity 4. Network Adequacy, 2023
- External Quality Review Optional Activity 6. Quality-of-Care Survey on Member Experience, 2023

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include “an assessment of the degree to which each MCP, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year’s EQR.” IPRO requested that each managed care plan describe how its organization addressed the recommendations from the *2022 External Quality Review Technical Report*. Managed Long-Term Care plan responses are reported in this section of the report.

Table 34 displays the assessment categories used by IPRO to describe Managed Long-Term Care plan progress towards addressing the 2022 external quality review recommendations.

Table 34: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
Managed Long-Term Care plan’s quality improvement response resulted in demonstrated improvement.
Partially Addressed
Managed care plan’s quality improvement response was appropriate; however, more time is needed to observe for performance improvement.
Remains an Opportunity for Improvement
Managed care plan’s quality improvement response did not address the recommendation; or performance declined.

Performance Improvement Project Summary and Results, 2023

This section displays a comprehensive summary of the Managed Long-Term Care plans' performance improvement projects that were in place in 2023. Each summary includes the project topic, the external quality review organization's validation statement, study populations, aims, a description of key interventions, and results achieved. The corresponding tables display performance indicators, baseline rates, interim rates, final rates, and targets/goals. A Managed Long-Term Care plan's performance indicator showing improvement from the baseline or meeting/exceeding the established target were considered strengths during this evaluation, while opportunities for improvement were noted when an indicator demonstrated performance decline from the baseline or did not meet the established target. Four performance indicators were evaluated for strengths or opportunities for improvement: the percentage of new enrollees with a completed stand-alone social determinants of health assessment, the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment, the percentage of care manager contacts where a social determinants of health screen is conducted, and the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s).

Performance Measures Results, 2023

This section displays the Managed Long-Term Care plan performance rates for measurement years 2022 and 2023, as well as the program average rates for measurement year 2023. The corresponding tables indicate whether the Managed Long-Term Care plan's rate was statistically better than the program average rate (indicated by green shading) or statistically worse than the program average rate (indicated by red shading). A Managed Long-Term Care plan rate statistically exceeding the program average rate for a measure was considered a strength during this evaluation, while a Managed Long-Term Care plan rate reported statistically below the program average rate was considered an opportunity for improvement.

Compliance with Medicaid Standards Results, 2021-2023

This section displays Managed Long-Term Care plan results for the 2021 through 2023 compliance activities conducted within the three-year period. A Managed Long-Term Care plan meeting compliance with federal Medicaid standards in 2023 was considered a strength during this evaluation, while noncompliance with a required standard was considered an opportunity for improvement.

Network Adequacy Results, 2023

This section displays managed care plan results for the 2023 fourth quarter Provider Network Data System review. A managed care plan meeting the federally required network adequacy standards was considered a strength. Any gap in the managed care plan's network identified in their Statement of Agreement was considered an opportunity for improvement, with the recommendation that the managed care plan pursues provider contracts to reduce the gap(s) identified in their Statement of Agreement.

Quality-of-Care Survey Results – Member Experience, 2023

This section displays the Managed Long-Term Care plan performance for 2021 and 2023. The corresponding tables display the individual measures, managed care plan scores, and the statewide average scores for measurement years 2021 and 2023. The table also indicates whether the managed care plan's score was significantly better than the statewide average score (indicated by green shading) or whether the managed care

plan’s score was significantly worse than the statewide average score (indicated by red shading). A managed care plan scoring statistically better than the statewide average score for a quality of care measure during the 2023 measurement year was considered a strength, while a managed care plan scoring statistically worse than the statewide average score during the 2023 measurement year was considered an opportunity for improvement.

Strengths, Opportunities for Improvement, and Recommendations, 2023

The Managed Long-Term Care plan’s strengths and opportunities for improvement identified during IPRO’s external quality review of the activities are described and enumerated in this section. For areas needing improvement, recommendations to improve the **quality** of, **timeliness** of, and **access** to care are presented. These three elements are defined as:

- **Quality** is the extent to which a managed care plan increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- **Timeliness** is the extent to which care and services are provided within the periods required by the New York State model contract with managed care plans, federal regulations, and as recommended by professional organizations and other evidence-based guidelines.
- **Access** is the timely use of personal health services to achieve the best possible health outcomes.

The strengths and opportunities for improvement based on the Managed Long-Term Care plans’ 2023 performance, as well as recommendations for improving **quality**, **timeliness**, and **access** to care are presented in this section (in table format). In these tables, links between strengths, opportunities, and recommendations to **quality**, **timeliness** and **access** are made by IPRO (indicated by ‘X’). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Medicaid Advantage Plus Managed Long-Term Care Plans

AgeWell	102
Centers Plan	107
Elderplan.....	114
Empire BCBS HealthPlus.....	123
Fidelis Care	130
Hamaspik	138
MetroPlus	147
MHI Healthfirst.....	155
RiverSpring.....	164
Senior Whole Health.....	171
VillageCare	178
VNS Health	185

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

AgeWell Medicaid Advantage Plus had a withdrawal effective 12/31/2023.

Performance Improvement Project Summaries and Results

Table 35: AgeWell’s Performance Improvement Project Summary, 2023

AgeWell’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">▪ AgeWell aims to increase the social determinants of health screening rate of new enrollees within the first 30 days of enrollment.▪ AgeWell aims to reduce the positive social determinants of health screening rate through quarterly social determinants of health assessments to follow-up on members’ response to clinical and non-clinical interventions.▪ AgeWell aims to increase the social determinants of health screening rate to identify social determinants of health issues among members.▪ AgeWell aims to reduce positive social determinants of health among members with a positive social determinants of health screen.▪ AgeWell aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted to reduce the rate of members with a positive social determinants of health screen and perform appropriate referrals and interventions.
<p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Developed and implemented a stand-alone social determinants of health assessment modeled after the Centers for Medicare and Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool.▪ Created a tracking and reporting tool for identifying social determinants of health needs for members to initiate referrals, as well as a process for following up on referrals.▪ Assembled a directory of community resources for members, which are available on AgeWell’s website and distributed in member newsletters.▪ Trained care managers on available community-based resources to help direct members with social determinants of health issues.

Table 36: AgeWell’s Performance Improvement Project Indicator Summary, Measurement Years 2021 – 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	10.00%	47.92%	30.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	32.06%	47.69%	30.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	27.14%	20.56%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	2.60%	4.08%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	28.57%	100%	30.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 37: AgeWell Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	46%	64%	68%
No Severe Daily Pain	Not Available	96%	89%	96%
Pain Controlled	Not Available	98%	100%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	70%	67%	78%
Pneumococcal Vaccination	Not Available	57%	57%	80%
COVID-19 Vaccination ³	Not Available	Not Available	Small Sample	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 38: AgeWell Medicaid Advantage Plus Network Gaps, Quarter 4 2023

AgeWell Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care		1
Fiscal Intermediary		1
Home Delivered and Congregate Meals		2
Institutional Long Term Care (AIDS Skilled Nursing Facility)		2
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	1
Opioid Treatment Program	4	2
Social and Environmental Support	2	
Telehealth	4	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

AgeWell’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 39: AgeWell’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	AgeWell’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by AgeWell demonstrated improvement between measurement years 2022 and 2023. Three performance improvement indicators exceeded AgeWell’s 2023 target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for AgeWell for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	AgeWell met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by AgeWell demonstrated performance decline between measurement years 2022 and 2023. The same performance improvement indicator did not reach AgeWell's 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	AgeWell has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project, Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy, Quality-of-Care Survey	AgeWell announced a withdrawal effective 12/31/2023; AgeWell is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendations were made.			

Centers Plan

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 40: Centers Plan’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Centers Plan’s Response	IPRO’S Assessment of Centers Plan’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Centers Plan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Centers Plan implemented the performance improvement project Searching for Health Equity through the identification of social determinants of health in 2022. Progress was monitored on a monthly basis and Centers Plan met the goal of screening members at greater than 90%. Centers Plan successfully launched and educated care managers on the screening tool in the care management software. The impact of the intervention was monitored and member refusal due to time constraints was identified as a main barrier. The barrier was addressed by prioritizing the social determinants of health screening and intervention in each member contact.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Centers Plan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes.</p>	<p>Centers Plan’s Medicaid Advantage Plus plan fell slightly below the statewide average for preventive screenings including dental, vision, and hearing exams. To address this gap, the Medicaid Advantage Plus Care Management team renewed efforts to increase education on the importance of preventive screenings and offer assistance to schedule appointments. The team also offered assistance in coordinating transportation to and</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Centers Plan's Response	IPRO'S Assessment of Centers Plan's Response
To address this, Centers Plan should focus on enhancing areas of care where their rates are below the Medicaid Managed Long-term Care program mean.	from the appointment, and by exploring the option for in-home provider visits for members who are homebound.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Centers Plan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Centers Plan continues to conduct auditing and monitoring activities to ensure compliance with federal and state Medicaid standards. Annually, a risk assessment is conducted and an audit plan is created. Centers Plan also has a Delegated Vendor Oversight Team that works with vendors to ensure that they are meeting quality standards, federal, and state regulations; Centers Plan's Compliance Department participates in regulatory meetings to stay apprised of any changes that require an adjustment to current processes.	Addressed.

Performance Improvement Project Summaries and Results

Table 41: Centers Plan’s Performance Improvement Project Summary, 2023

Centers Plan’s Performance Improvement Project Summary
<p>Title: Searching for Health Equity through Identification of Social Determinants of Health</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none"> Centers Plan aims to complete a social determinants of health assessment for new and continuing enrollees and improve the documentation of referrals and follow-up made for members at-risk for social determinants of health needs. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Conducted care management training for all new staff. Integrated an evidence-based social determinants of health assessment tool and referrals into Centers Plan’s care management platform. Enhanced the care management system with automated reports to track social determinants of health assessment indicators. Created a comprehensive referral list for care management use based on social determinants of health needs.

Table 42: Centers Plan’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	78.54%	83.27%	40.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	95.93%	98.66%	40.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	52.70%	92.38%	28.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.82%	5.95%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	88.37%	93.33%	60.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 43: Centers Plan Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	51%	44%	68%
No Severe Daily Pain	Not Available	88%	87%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	77%	76%	78%
Pneumococcal Vaccination	Not Available	89%	88%	80%
COVID-19 Vaccination ³	Not Available	Not Available	45%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 44: Centers Plan Medicaid Advantage Plus Network Gaps, Quarter 4 2023

Centers Plan Medicaid Advantage Plus Network Gaps Quarter 4 2023	
Provider Type With A Gap ¹	Gap Type
	County Choice
Adult Day Health Care	1
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1
Opioid Treatment Program	3

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 45: Centers Plan’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Centers Plan Measurement Year 2021	Centers Plan Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	Sample Size Too Small To Report	85%	82%
Rating of Dentist	Sample Size Too Small To Report	71%	72%
Rating of Care Manager	Sample Size Too Small To Report	90%	87%
Rating of Regular Visiting Nurse	Sample Size Too Small To Report	80%	84%
Rating of Home Health Aide	Sample Size Too Small To Report	93%	93%
Rating of Transportation Services	Sample Size Too Small To Report	66%	72%
Timeliness of Home Health Aide	Sample Size Too Small To Report	96%	95%
Timeliness Composite	Sample Size Too Small To Report	85%	85%
Involved in Decisions	Sample Size Too Small To Report	85%	84%
Manage Illness	Sample Size Too Small To Report	86%	85%
Access to Routine Dental Care	Sample Size Too Small To Report	29%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%	26%
Plan Asked to See Medicines	Sample Size Too Small To Report	91%	93%
Talked About Appointing for Health Decisions	Sample Size Too Small To Report	83%	74%
Document Appointing for Health Decisions	Sample Size Too Small To Report	62%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	88%	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 46: Centers Plan’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Centers Plan’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Centers Plan demonstrated improvement between measurement years 2022 and 2023. All four performance improvement indicators	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	reported by Centers Plan exceeded their 2023 target rates.			
Performance Measures	One performance measure rate calculated by the Department of Health for Centers Plan for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Centers Plan met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Centers Plan performed significantly better than the Medicaid Managed Long-Term Care program on one measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Centers Plan for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Centers Plan has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Centers Plan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Centers Plan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Centers Plan should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Centers Plan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended that Centers Plan pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Centers Plan should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 47: Elderplan’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Elderplan’s Response	IPRO’S Assessment of Elderplan’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Elderplan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Elderplan exceeded project goals of social determinants of health assessment completion and care management contact. Elderplan continues to complete social determinants of health assessments with every care planning call to identify social barriers and risks, as well as implementing appropriate interventions to address them. A social work coordinator was hired in 2023 to ensure that targeted interventions are continuously developed and followed up on. Ongoing education is provided to all care management staff to ensure members’ needs are met and outcomes are properly monitored.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Elderplan should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderplan should focus on enhancing areas of care where its rates are</p>	<p>Elderplan members are frail with multiple comorbidities. In 2023, Elderplan focused on preventing worsened shortness of breath through disease management and transitions of care programs, partnership with community-based organizations for home visits post-acute episode, referrals to certified home health care agencies, and ongoing member education on disease progression. Elderplan utilizes plan-do-study-act methodology to determine program effectiveness, with Elderplan data collected over time for the</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Elderplan's Response	IPRO'S Assessment of Elderplan's Response
below the Managed Long-term Care program mean.	shortness of breath measure revealing successful program outcomes, as the rate was 90%, above the statewide average.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Elderplan continues to conduct routine monitoring and auditing, focusing on member impact and keeping policies and procedures up-to-date with federal and state requirements. Elderplan assesses for non-compliance, fraud, waste, and abuse in risk areas enrollment, call center, care management, pre/post-service requests, appeals and grievances, pharmacy, quality improvement, network/contracting, marketing, and vendor oversight. Elderplan successfully passed the Center for Medicare and Medicaid Services Program Integrity Audit of 2021 and 2022.	Addressed.

Performance Improvement Project Summaries and Results

Table 48: Elderplan’s Performance Improvement Project Summary, 2023

Elderplan’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none">▪ Elderplan aims to increase the percentage of members with social determinants of health assessments among new and continuously enrolled members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Enhanced annual training program to include social determinants of health tool and available community resources.▪ Updated workflow to include requirement to complete social determinants of health screening tool at least once a year. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Developed individualized care plans with targeted interventions for members with needs by the social determinants of health tool.

Table 49: Elderplan’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	93.65%	98.36%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	98.50%	99.53%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	10.76%	26.65%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	72.50%	52.89%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 50: Elderplan Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	43%	37%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	76%	78%	78%
Pneumococcal Vaccination	Not Available	83%	85%	80%
COVID-19 Vaccination ³	Not Available	Not Available	81%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 51: Elderplan Medicaid Advantage Plus Network Gaps, Quarter 4 2023

Elderplan Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care		2
Audiology Services	1	1
Institutional Long Term Care (AIDS Skilled Nursing Facility)		1
Opioid Treatment Program		5
Optometry	1	
Oral Surgery	1	1
Podiatry		1
Social Day Care		4

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 52: Elderplan’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Elderplan Measurement Year 2021	Elderplan Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	93%	87%	82%
Rating of Dentist	75%	58%	72%
Rating of Care Manager	93%	91%	87%
Rating of Regular Visiting Nurse	91%	84%	84%
Rating of Home Health Aide	97%	96%	93%
Rating of Transportation Services	71%	68%	72%
Timeliness of Home Health Aide	97%	98%	95%
Timeliness Composite	91%	89%	85%
Involved in Decisions	83%	84%	84%
Manage Illness	87%	88%	85%
Access to Routine Dental Care	50%	40%	35%
Same Day Urgent Dental Care	40%	34%	26%
Plan Asked to See Medicines	99%	96%	93%
Talked About Appointing for Health Decisions	88%	82%	74%
Document Appointing for Health Decisions	78%	76%	61%
Plan Has Document Appointing for Health Decisions	91%	88%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance. **Green shading** indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 53: Elderplan’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderplan’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Elderplan demonstrated improvement between measurement years 2022 and 2023. One of four performance improvement indicator rates remained static between measurement years 2022 and 2023. All four performance improvement project indicators exceeded Elderplan’s 2023 target rates, including the indicator that showed decline from 2022-2023.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Elderplan for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Elderplan met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Elderplan performed significantly better than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Elderplan demonstrated performance decline between measurement years 2022 and 2023	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Elderplan for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Elderplan has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Elderplan performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Elderplan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Elderplan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderplan should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Elderplan pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	Elderplan should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Empire BCBS HealthPlus

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 54: Empire BCBS HealthPlus’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Empire BCBS HealthPlus’s Response	IPRO’S Assessment of Empire BCBS HealthPlus’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Empire BCBS HealthPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Empire HealthPlus Medicaid Advantage Plus conducted a performance improvement project to improve social determinants of health screening, achieving all four goals. We continue to monitor these performance indicators and as we implement the New York State Medicaid Social Care Initiative to enhance social care services and collaboration between HRSN providers and care managers, the Plan will assess the effectiveness of our interventions to ensure ongoing improvement. We will maintain highly effective interventions and modify or replace those with low impact.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Empire BCBS HealthPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Empire BCBS HealthPlus should</p>	<p>The 2022 external quality review showed Empire BCBS HealthPlus Medicaid Advantage Plus exceeded the statewide average in one measure (No Shortness of Breath). Two measures (Pneumovax & Flu vaccinations) were below the 50th percentile, two measures (Not Lonely & Distressed, & Pain Controlled) met/or exceeded the 90th percentile, and one measure (No Severe or Intense Daily Pain) reached the 75th percentile. We have implemented improvement strategies, including best practice</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Empire BCBS HealthPlus's Response	IPRO'S Assessment of Empire BCBS HealthPlus's Response
focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	training & will continue to monitor progress.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	The NY Medicaid Compliance Committee meets ten times per year and reviews the following: monthly operational scorecard of Medicaid standards; all Statements of Deficiency/Finding received; and results of audits/oversight. Also, representatives across functional areas assess the impact of state mandates/guidance via the Compliance 360 system; evidence of gap closure is required. Updates are provided to the Quality Management Committee.	Addressed.

Performance Improvement Project Summaries and Results

Table 55: Empire BCBS HealthPlus's Performance Improvement Project Summary, 2023

Empire BCBS HealthPlus's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> Empire BCBS HealthPlus aims to increase the percentage of completed social determinants of health screenings and interventions for managed long-term care and fully integrated dual eligible members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Educated staff on the prevalence and health impacts of social determinants of health among the managed long-term care population. Created system-generated reports to allow care managers to monitor and track identified social determinants of health needs and interventions.

Table 56: Empire BCBS HealthPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement	Interim Measurement	Final Measurement ¹	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	36.56%	100.00%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	75.38%	58.88%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	97.38%	No Data To Report	10.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	22.82%	4.76%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	75.00%	100%	33.00%

¹ Due to a merger during the course of the performance improvement plan, the final measurement period was July 1, 2023, to December 31, 2023.

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 57: Empire BCBS HealthPlus Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	93%	89%	68%
No Severe Daily Pain	Not Available	100%	100%	96%
Pain Controlled	Not Available	100%	100%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	70%	82%	78%
Pneumococcal Vaccination	Not Available	71%	87%	80%
COVID-19 Vaccination ³	Not Available	Not Available	81%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 58: Empire BCBS HealthPlus Medicaid Advantage Plus Network Gaps, Quarter 4 2023

Empire BCBS HealthPlus Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	4	
Fiscal Intermediary	4	
General Dentistry	2	
Institutional Long Term Care	1	
Institutional Short Term Care		1
Non-Emergent Transportation		3
Opioid Treatment Program		5
Optometry		2
Oral Surgery	2	
Personal Emergency Response		9
Social Day Care	4	1
Telehealth	2	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Empire BCBS HealthPlus’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 59: Empire BCBS HealthPlus’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Empire BCBS HealthPlus’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Note that due to a merger, during the course of the performance improvement plan, Empire BCBS HealthPlus reported that the baseline measurement period was December 2022 only; the interim measurement period was January 1 st , 2023, to June 30 th , 2023; and, the final measurement period was July 1 st , 2023, to December 31 st , 2023. Two of four performance improvement project indicator rates reported by Empire BCBS HealthPlus demonstrated	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	improvement between the modified Interim and Final measurement periods. One of four performance improvement project indicator rates reported by Empire BCBS HealthPlus had no data to report for the modified Interim. Three performance improvement indicators exceeded Empire BCBS HealthPlus's 2023 target rates.			
Performance Measures	One performance measure rate calculated by the Department of Health for Empire BCBS HealthPlus for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Empire BCBS HealthPlus met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Note that due to a merger, during the course of the performance improvement plan, Empire BCBS HealthPlus reported that the baseline measurement period was December 2022 only; the interim measurement period was January 1 st , 2023, to June 30 th , 2023; and, the final measurement period was July 1 st , 2023, to December 31 st , 2023. One of four performance improvement project indicator rates reported by Empire BCBS HealthPlus had no data to report for the modified Interim and Final measurement periods and did not reach the 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Empire BCBS HealthPlus has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	the provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Empire BCBS HealthPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Empire BCBS HealthPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Empire BCBS HealthPlus should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Empire BCBS HealthPlus pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Empire BCBS HealthPlus should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 60: Fidelis’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Fidelis’s Response	IPRO’S Assessment of Fidelis’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Fidelis Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Fidelis continues to monitor for performance improvement via robust management reports and monthly Quality Committee meetings. Fidelis continues to utilize the data pulled from the social determinants of health performance improvement project on a daily basis to inform on needs, referrals, and follow-up. This has benefited behavior health and Medicaid Advantage Plus members, as their care managers collaborate regularly to meet the needs of shared members. There was great success and a continued streamline process post-performance improvement project to continue a collaborative approach.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Fidelis Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fidelis Care should focus on enhancing</p>	<p>Fidelis has in place regular monitoring of members’ health assessment data. Members with gaps in care are identified and encouraged to access care, are offered assistance with appointments, or are offered in-home services where appropriate to promote health and prevent unfavorable outcomes. Fidelis has modified its monthly call script and in-home care management visits to enhance positive messaging.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Fidelis's Response	IPRO'S Assessment of Fidelis's Response
areas of care where its rates are below the Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Fidelis has a robust routine monitoring program to ensure compliance with federal and state standards. Fidelis Care conducts semi-annual mock survey reviews of a random sample of member records. Results of the mock surveys are reported to Fidelis Compliance for review and monitoring.	Addressed.

Performance Improvement Project Summaries and Results

Table 61: Fidelis Care's Performance Improvement Project Summary, 2023

Fidelis Care's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among new enrollees within the first 30 days of enrollment. ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among continuously enrolled members. ▪ Fidelis Care aims to increase the percentage of care manager contacts where a stand-alone social determinants of health screening was conducted. ▪ Fidelis Care aims to increase the percentage of members with documented action taken to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Updated care management workflow to include member education on the importance of completing assessments. ▪ Educated staff on the impact of social determinants of health, assessment tools, and resources available. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Published a member newsletter article on social determinants of health resources. ▪ Linked members identified with a positive social determinants of health assessment to appropriate resources based on member need.

Table 62: Fidelis Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	47.87%	76.07%	70.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	82.64%	91.85%	70.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	76.68%	98.97%	90.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	17.58%	25.34%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	90.63%	98.80%	35.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 63: Fidelis Care Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	74%	73%	68%
No Severe Daily Pain	Not Available	95%	87%	96%
Pain Controlled	Not Available	97%	96%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	65%	69%	78%
Pneumococcal Vaccination	Not Available	58%	71%	80%
COVID-19 Vaccination ³	Not Available	Not Available	78%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 64: Fidelis Care Medicaid Advantage Plus Network Gaps, Quarter 4 2023

Fidelis Care Medicaid Advantage Plus Network Gaps Quarter 4 2023				
Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Adult Day Health Care		4		
Assertive Community Treatment	6	15		
Audiology Services	1	1		
Comprehensive Psychiatric Emergency Program	1			
Core Community Psychiatric Supports and Treatments	7	10		
Core Family Support and Training	3	13		
Core Peer Support	11	10		
Core Psychosocial Rehabilitation	3	11		
Fiscal Intermediary	1	4		1
Inpatient Chemical Dependency	1	3		
Inpatient Mental Health		5		
Institutional Long Term Care		1		
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	1		
Institutional Short Term Care		1		
Medically Managed Detox Services		4		
Medically Supervised Detox Services (Inpatient)	9	10		
Medically Supervised Detox Services (Outpatient)		1		
Opioid Treatment Program	2	21		
Optometry	12			
Oral Surgery	2	4		
Outpatient Chemical Dependency – Clinic		9		
Outpatient Chemical Dependency – Outpatient Rehabilitation	2	1		
Outpatient Mental Health Clinic	2	14		
Outpatient Mental Health Clinic – State Operated		4		
Partial Hospitalization	8	13	1	1
Personalized Recovery Oriented Services, Continuing Day Treatment		1		
Podiatry		1		
Residential Substance Abuse Treatment Services	1	7		
Social Day Care	3	4	2	3
Telehealth	4	3		
Therapy: Occupational	2			
Therapy: Physical	1			
Therapy: Respiratory	4			
Therapy: Speech and Language	2			

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 65: Fidelis Care’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	Sample Size Too Small To Report	87%	82%
Rating of Dentist	Sample Size Too Small To Report	73%	72%
Rating of Care Manager	Sample Size Too Small To Report	85%	87%
Rating of Regular Visiting Nurse	Sample Size Too Small To Report	80%	84%
Rating of Home Health Aide	Sample Size Too Small To Report	94%	93%
Rating of Transportation Services	Sample Size Too Small To Report	67%	72%
Timeliness of Home Health Aide	Sample Size Too Small To Report	98%	95%
Timeliness Composite	Sample Size Too Small To Report	85%	85%
Involved in Decisions	Sample Size Too Small To Report	82%	84%
Manage Illness	Sample Size Too Small To Report	87%	85%
Access to Routine Dental Care	Sample Size Too Small To Report	26%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	26%
Plan Asked to See Medicines	Sample Size Too Small To Report	91%	93%
Talked About Appointing for Health Decisions	Sample Size Too Small To Report	71%	74%
Document Appointing for Health Decisions	Sample Size Too Small To Report	60%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	Sample Size Too Small To Report	85%

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 66: Fidelis Care’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Fidelis Care demonstrated improvement between measurement years 2022 and 2023. All four	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	performance improvement indicators exceeded Fidelis Care’s 2023 target rates.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Fidelis Care met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Fidelis Care for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Fidelis Care has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fidelis Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Fidelis Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fidelis Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Fidelis Care pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Fidelis Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 67: Hamaspik’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Hamaspik’s Response	IPRO’S Assessment of Hamaspik’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Hamaspik should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Hamaspik continued to incorporate social determinants of health into care management training and services for members through 2024 and into 2025. Resources are maintained and updated for staff and members to ensure interventions can be implemented and carried out as needed. By the end of 2023, Hamaspik consistently targeted education and collaboration with members and providers to support successful interventions of positive social determinants of health indicators.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Hamaspik should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Hamaspik should focus on enhancing areas of care where its rates are</p>	<p>Hamaspik monitored performance rates on a weekly basis in comparison to the most recent data from the crude reports showing statewide percentiles and averages. Interventions and improvement are targeted to measures performing lower than average.</p>	<p>Partially addressed.</p>

2022 External Quality Review Recommendation	Hamaspik's Response	IPRO'S Assessment of Hamaspik's Response
below the Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Hamaspik's compliance department includes staff who conduct internal audits focused on key elements of managed long-term care and Medicaid Advantage Plus compliance. Audits include care management contact frequency and documentation; enrollment and disenrollment documentation; utilization review and appeals timeliness and documentation; consumer-directed personal assistance services documentation; member services standards for timeliness and accuracy; and utilization of key services that determine member eligibility.	Addressed.

Performance Improvement Project Summaries and Results

Table 68: Hamaspik's Performance Improvement Project Summary, 2023

Hamaspik's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for new members within the first 30 days of enrollment.▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for members who have been continuously enrolled.▪ Hamaspik aims to improve the rate of care manager contacts where a social determinants of health screen is conducted.▪ Hamaspik aims to determine the percentage of members who have a positive social determinants of health assessment.▪ Hamaspik aims to improve the rate of members with a positive social determinants of health assessment who have documented interventions to address the identified need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Trained care managers on social determinants of health. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Created a member education tool highlighting key plan benefits and community resources that address social determinants of health concerns. <p><u>Provider-Focused 2023 Intervention</u></p> <ul style="list-style-type: none">▪ Collaborated with in-network home care services agencies and primary care providers to engage members with positive social determinants of health indicators.

Table 69: Hamaspik’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	18.95%	20.45%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	Not Available	67.92%	25.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	1.61%	52.29%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	72.22%	30.58%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	94.44%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 70: Hamaspik Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	85%	69%	68%
No Severe Daily Pain	Not Available	98%	98%	96%
Pain Controlled	Not Available	98%	98%	98%
Not Lonely or Not Distressed	Not Available	98%	98%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	81%	77%	78%
Pneumococcal Vaccination	Not Available	77%	80%	80%
COVID-19 Vaccination ³	Not Available	Not Available	67%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 71: Hamaspik Medicaid Advantage Plus Network Gaps, Quarter 4 2023

Hamaspik Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	1	4
Audiology Services	1	1
Home Delivered and Congregate Meals		1
Institutional Long Term Care (AIDS Skilled Nursing Facility)	2	
Opioid Treatment Program		7
Optometry	3	
Oral Surgery	1	1
Telehealth	2	2
Therapy: Respiratory	12	
Therapy: Speech and Language	2	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 72: Hamaspik’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Hamaspik Measurement Year 2021	Hamaspik Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	Sample Size Too Small To Report	83%	82%
Rating of Dentist	Sample Size Too Small To Report	68%	72%
Rating of Care Manager	Sample Size Too Small To Report	80%	87%
Rating of Regular Visiting Nurse	Sample Size Too Small To Report	69%	84%
Rating of Home Health Aide	Sample Size Too Small To Report	91%	93%
Rating of Transportation Services	Sample Size Too Small To Report	72%	72%
Timeliness of Home Health Aide	Sample Size Too Small To Report	93%	95%
Timeliness Composite	Sample Size Too Small To Report	81%	85%
Involved in Decisions	Sample Size Too Small To Report	86%	84%
Manage Illness	Sample Size Too Small To Report	88%	85%

Measure	Hamaspik Measurement Year 2021	Hamaspik Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Access to Routine Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	26%
Plan Asked to See Medicines	Sample Size Too Small To Report	88%	93%
Talked About Appointing for Health Decisions	Sample Size Too Small To Report	59%	74%
Document Appointing for Health Decisions	Sample Size Too Small To Report	63%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	Sample Size Too Small To Report	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 73: Hamaspik’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Hamaspik’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Hamaspik demonstrated improvement between measurement years 2022 and 2023. Three performance improvement project indicator rates exceeded Hamaspik’s 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network adequacy	Hamaspik met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	One of four performance improvement project indicator rates reported by Hamaspik demonstrated performance decline between measurement years 2022 and 2023. The same performance improvement indicator rate did not reach Hamaspik's 2023 target rate.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Hamaspik has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Hamaspik performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Hamaspik should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Hamaspik should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Hamaspik should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Hamaspik pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Hamaspik should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 74: MetroPlus’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	MetroPlus’s Response	IPRO’S Assessment of MetroPlus’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, MetroPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>MetroPlus continues to monitor and review clinical documentation associated with social determinants of health to better support members’ individual needs. MetroPlus utilizes a stand-alone social determinants of health assessment. Care managers make monthly calls to identified members and provide focused interventions. MetroPlus continues to monitor monthly and conducts the stand-alone assessment annually, which allows for continuous quality improvement.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>MetroPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, MetroPlus should focus on enhancing areas of care where its rates are</p>	<p>MetroPlus has implemented utilization of the quality analysis software, Lenavi, to monitor and track gaps in care noted on the health assessment. The Universal Assessment System assessor utilizes the Lenavi system to perform quality checks. The Care Management team then develops individualized goals and interventions for each member. Minimally, monthly contact is made with each member to review interventions, goals, and outcomes to ensure members are receiving</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	MetroPlus's Response	IPRO'S Assessment of MetroPlus's Response
below the Medicaid Managed Long-term Care program mean.	adequate care and improved health outcomes.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
MetroPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	MetroPlus continues to maintain a compliance program with an assigned compliance specialist to ensure adherence to all applicable requirements. Through a risk assessment, MetroPlus' Compliance Committee develops an annual compliance workplan which is then executed by the compliance team. Identified risks such as utilization, grievance, appeals, and claims are included and monitored regularly. These findings are then reported to MetroPlus' governing body.	Addressed.

Performance Improvement Project Summaries and Results

Table 75: MetroPlus’s Performance Improvement Project Summary, 2023

MetroPlus’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">▪ MetroPlus aims to increase the rate for social determinants of health screening among new members.▪ MetroPlus aims to increase the rate for social determinants of health screening among continuously enrolled members.▪ MetroPlus aims to increase subsequent follow-up to address social determinants of health needs among members with a positive screen using clinical and non-clinical interventions. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Enabled a system generated report to support quarterly monitoring of members with social determinants of health needs.▪ Trained care managers on the use of the social determinants of health screening tool and appropriate selection of interventions. <p><u>Member-Focused 2023 Intervention</u></p> <ul style="list-style-type: none">▪ Monitored members with a positive social determinants of health assessment to ensure implementation of at least one intervention.

Table 76: MetroPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Medicaid Advantage Plus Enrollment	13.64%	70.83%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Medicaid Advantage Plus Enrollment	95.00%	87.72%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Medicaid Advantage Plus Enrollment	7.01%	10.34%	50.00%
Percentage of members with a positive social determinants of health assessment	No Medicaid Advantage Plus Enrollment	0.00%	28.40%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Medicaid Advantage Plus Enrollment	0.00%	97.83%	50.00%

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 77: MetroPlus Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	Small Sample	86%	68%
No Severe Daily Pain	Not Available	Small Sample	100%	96%
Pain Controlled	Not Available	Small Sample	97%	98%
Not Lonely or Not Distressed	Not Available	Small Sample	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	Small Sample	76%	78%
Pneumococcal Vaccination	Not Available	Small Sample	76%	80%
COVID-19 Vaccination ³	Not Available	Not Available	89%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 78: MetroPlus Medicaid Advantage Plus Network Gaps, Quarter 4 2023

MetroPlus Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Institutional Long Term Care		1
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	1
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	
Licensed Home Health Care: Home Based Medical Social Services		4
Licensed Home Health Care: Home Based Speech Therapy		4
Opioid Treatment Program		1
Private Duty Nursing	1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

MetroPlus’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 79: MetroPlus’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by MetroPlus demonstrated improvement between measurement years 2022 and 2023. Three of four performance improvement indicator rates exceeded MetroPlus’s 2023 target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for MetroPlus for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	MetroPlus met the federal requirements for Network Adequacy.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by MetroPlus demonstrated a decline between measurement years 2022 and 2023. One performance improvement indicator rate did not reach MetroPlus's 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	MetroPlus has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MetroPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	MetroPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, MetroPlus should focus on enhancing areas of	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	MetroPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended MetroPlus pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, MetroPlus should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 80: MHI Healthfirst’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Healthfirst’s Response	IPRO’S Assessment of Healthfirst’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, MHI Healthfirst should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Care managers continue to complete social determinants of health assessments and implement appropriate interventions. Technological enhancements are utilized to identify and manage members missing a social determinants of health screening, including an automated report, an alert within MHI Healthfirst's case management system, and a Power Business Intelligence tool that analyzes social determinants of health data. Senior staff uses the reports to ensure that members are screened annually and to monitor care plans missing social determinants of health interventions.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>MHI Healthfirst should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Healthfirst should focus on</p>	<p>MHI Healthfirst develops programs and partnerships to promote preventive care, address social determinants of health needs, and manage chronic issues. Care managers reach out to members monthly to address care gaps, answer questions, coordinate care, and identify new risks. Teams that close the most care gaps each month are recognized in team meetings. To ensure health outcome improvements, teams routinely meet to monitor measure-</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Healthfirst's Response	IPRO'S Assessment of Healthfirst's Response
enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	and member-level performance and adjust strategies as needed.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
MHI Healthfirst should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	As part of MHI Healthfirst's ongoing preparation activities for the Department of Health compliance review, all relevant business units review prior results to confirm compliance with federal and state Medicaid standards. In addition, the Compliance and Regulatory teams work collaboratively to monitor and review continuing compliance.	Addressed.

Performance Improvement Project Summaries and Results

Table 81: MHI Healthfirst’s Performance Improvement Project Summary, 2023

MHI Healthfirst’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">▪ MHI Healthfirst aims to improve the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment.▪ MHI Healthfirst aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment.▪ MHI Healthfirst aims to improve the percentage of care manager contacts where a social determinants of health screen is conducted.▪ MHI Healthfirst aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs.
<p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Facilitated training and developed a job aide to educate case management staff on the new tools for social determinants of health screening/care planning, as well as the social determinants of health workflow.▪ Reviewed and updated social determinants of health screening toolkits, member educational materials, and a compilation of online / community resources posted on plan website semi-annually.
<p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Provided educational information on the importance of addressing social determinants of health barriers in achieving positive health outcomes and a compilation of online and community resources on our member website.▪ Conducted follow-up outreach to members within 30 days of the implementation of an intervention addressing a social determinant of health barrier.

Table 82: MHI Healthfirst’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	26.25%	86.59%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	83.09%	92.91%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	11.84%	9.95%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	10.02%	8.93%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	74.23%	98.85%	75.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 83: MHI Healthfirst Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	87%	84%	68%
No Severe Daily Pain	Not Available	99%	97%	96%
Pain Controlled	Not Available	96%	96%	98%
Not Lonely or Not Distressed	Not Available	96%	97%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	73%	73%	78%
Pneumococcal Vaccination	Not Available	71%	75%	80%
COVID-19 Vaccination ³	Not Available	Not Available	73%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 84: MHI Healthfirst Medicaid Advantage Plus Network Gaps, Quarter 4 2023

MHI Healthfirst Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	2	5
Assertive Community Treatment		1
Core Community Psychiatric Supports and Treatment		1
Core Family Support and Training		1
Core Peer Support		1
Core Psychosocial Rehabilitation		1
Fiscal Intermediary	2	
Medically Managed Detox Services		2
Medically Managed Detox Services – Inpatient		1
Opioid Treatment Program	4	2
Oral Surgery	1	
Residential Substance Abuse Treatment Services	1	
Social Day Care	3	
Therapy: Speech and Language	2	2

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 85: MHI Healthfirst’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	MHI Healthfirst Measurement Year 2021	MHI Healthfirst Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	88%	87%	82%
Rating of Dentist	74%	73%	72%
Rating of Care Manager	80%	84%	87%
Rating of Regular Visiting Nurse	80%	77%	84%
Rating of Home Health Aide	98%	92%	93%
Rating of Transportation Services	79%	69%	72%
Timeliness of Home Health Aide	93%	94%	95%
Timeliness Composite	78%	83%	85%
Involved in Decisions	87%	90%	84%
Manage Illness	82%	86%	85%
Access to Routine Dental Care	34%	39%	35%
Same Day Urgent Dental Care	31%	32%	26%
Plan Asked to See Medicines	96%	94%	93%
Talked About Appointing for Health Decisions	86%	80%	74%

Measure	MHI Healthfirst Measurement Year 2021	MHI Healthfirst Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Document Appointing for Health Decisions	65%	58%	61%
Plan Has Document Appointing for Health Decisions	90%	87%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 86: MHI Healthfirst’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MHI Healthfirst’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by MHI Healthfirst demonstrated improvement between measurement years 2022 and 2023. Three performance improvement project indicator rates exceeded MHI Healthfirst’s 2023 target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for MHI Healthfirst for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	MHI Healthfirst met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	MHI Healthfirst performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by MHI Healthfirst demonstrated performance decline between measurement years 2022 and 2023. One performance improvement indicator rate did not reach Healthfirst's 2023 target rate.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for MHI Healthfirst for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	MHI Healthfirst has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MHI Healthfirst should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	MHI Healthfirst should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	outcomes. To address this, MHI Healthfirst should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	MHI Healthfirst should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended MHI Healthfirst pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	MHI Healthfirst should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 87: Riverspring’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Riverspring’s Response	IPRO’S Assessment of Riverspring’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, RiverSpring should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Improvement plans are monitored continuously throughout the project via reporting, case review, and auditing. When interventions are validated as evidenced by progress towards meeting goals, those interventions continue. Negative outcomes are reviewed in depth to determine why the intervention is not effective and to identify new interventions that may better serve the goal and thereby, the member.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>RiverSpring should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, RiverSpring should focus on enhancing areas of care where its rates are</p>	<p>Community health assessment data and member satisfaction surveys are reviewed for areas of opportunity to improve member outcomes. For example, it was noted that RiverSpring members are below statewide average in having pain and shortness of breath controlled. In response to this, a pain assessment was added to the care manager assessment with a link to the care plan so that members’ pain is addressed with interventions developed to reduce or alleviate members’ pain.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Riverspring's Response	IPRO'S Assessment of Riverspring's Response
below the Medicaid Managed Long-term Care program mean.	Shortness of breath is addressed via appropriate services and supports.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
RiverSpring should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	RiverSpring conducts monthly auditing and monitoring of plan operations as part of its quality and compliance program. At a minimum, results are reported quarterly to stakeholders, with significant deviations reported to stakeholders immediately so corrective actions may be initiated. Auditing focuses on regulatory compliance and quality of care delivery to membership with a goal of providing optimal support and services to improve member health and well-being.	Addressed.

Performance Improvement Project Summaries and Results

Table 88: RiverSpring's Performance Improvement Project Summary, 2023

RiverSpring's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessment within the first 30 days of enrollment for all new Medicaid Advantage Plus members. ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessments for all continuously enrolled Medicaid Advantage Plus members. ▪ RiverSpring aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted for all newly and continuously enrolled Medicaid Advantage Plus members. ▪ RiverSpring aims to decrease the percentage of positive social determinants of health assessments for all newly and continuously enrolled Medicaid Advantage Plus members. ▪ RiverSpring aims to increase the percentage of documented interventions to address needs for all Medicaid Advantage Plus members with a positive social determinants of health assessment. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Trained staff on the social determinants of health screening tool, the prevalence and health impacts of social determinants of health, and community resources, which will be repeated annually for all staff and at orientation for new hires.

RiverSpring's Performance Improvement Project Summary

- Constructed a searchable inventory of local resources and supports organized by location and need.
- Integrated the social determinants of health assessment tool into existing systems utilized by care management.
- Developed a monitoring system within existing care management systems and workflows to ensure close-loop process for referring members to community services and supports.

Member-Focused 2023 Interventions

- Added a recurring section to the member newsletter on social determinants of health to provide ongoing education and resources to members.
- Added social determinants of health education to be discussed on monthly care management calls to members.

Table 89: RiverSpring's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	38.52%	88.35%	45.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	37.40%	36.10%	40.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	8.82%	24.07%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	8.60%	4.35%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	44.44%	71.43%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 90: RiverSpring Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	48%	49%	68%
No Severe Daily Pain	Not Available	100%	96%	96%
Pain Controlled	Not Available	89%	87%	98%
Not Lonely or Not Distressed	Not Available	98%	97%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	80%	85%	78%
Pneumococcal Vaccination	Not Available	71%	79%	80%
COVID-19 Vaccination ³	Not Available	Not Available	84%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 91: RiverSpring Medicaid Advantage Plus Network Gaps, Quarter 4 2023

RiverSpring Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	1	1
Audiology Services		1
Fiscal Intermediary	1	
General Dentistry	7	
Home Delivered and Congregate Meals		1
Institutional Short Term Care	1	1
Opioid Treatment Program	6	1
Optometry		1
Oral Surgery	7	
Telehealth	7	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

RiverSpring’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 92: RiverSpring’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	RiverSpring’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by RiverSpring demonstrated improvement between measurement years 2022 and 2023. Three performance improvement indicator rates exceeded RiverSpring’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	RiverSpring met the federal requirements for Network Adequacy.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One performance improvement indicator rate did not reach RiverSpring's 2023 target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for RiverSpring for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	RiverSpring has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, RiverSpring should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	RiverSpring should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, RiverSpring should	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	RiverSpring should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended RiverSpring pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, RiverSpring should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Senior Whole Health

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 93: Senior Whole Health’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Senior Whole Health’s Response	IPRO’S Assessment of Senior Whole Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Senior Whole Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Senior Whole Health continues to assess both newly enrolled and established members monthly via the social determinants of health assessment tool. As part of the current standard operating procedure, members with positive assessments are referred to community-based organizations to address immediate outstanding social needs.</p> <p>The interventions are evaluated monthly and found to be effective. Ineffective interventions are modified or replaced with more effective measures based on current workflow, evaluation, and feedback.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Senior Whole Health should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Whole Health should focus on enhancing areas of</p>	<p>Senior Whole Health continues to analyze and interpret health assessment data to shape the quality assurance/performance improvement project by identifying tracks, trends in quality indicators for gaps in care analysis, and health disparities, while determining members at risk. This process analysis uses appropriate interventions which are initiated when unfavorable or low performance rates are returned, such as the rate of new enrollees with stand-alone social determinants of health</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Senior Whole Health's Response	IPRO'S Assessment of Senior Whole Health's Response
care where its rates are below the Medicaid Managed Long-term Care program mean.	assessments. This methodology improved rates above the goal and optimized member outcomes.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Senior Whole Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Senior Whole Health conducts various types of internal reviews ensuring compliance. Self-monitoring, auditing, and mandatory trainings are conducted at regular intervals throughout the year and annually. Senior Whole Health's compliance department conducts continuous risk assessments which develops the internal audit work plan. Quarterly audits are performed, corrective action plans are issued for non-compliance, and continual feedback is provided to reinforce overall compliance at every level.	Addressed.

Performance Improvement Project Summaries and Results

Table 94: Senior Whole Health's Performance Improvement Project Summary, 2023

Senior Whole Health's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Senior Whole Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Whole Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ Senior Whole Health aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p>

Senior Whole Health's Performance Improvement Project Summary

- Developed discreet data reporting from the standardized PRAPARE/AAFP-SNST tool to readily allow for identification of members with social determinants of health needs.
- Developed, documented, and tracked a comprehensive member referral process to access, link, and coordinate members with identified social determinants of health needs. Performed a clinical quality audit regarding social determinants of health outcomes.
- Trained all Care Management and Quality staff on social determinants of health and PRAPARE/AAFP-SNST standardized assessment tool and workflow process.
- Educated licensed home care services agency providers on how to use the “Molina Help Finder” platform to identify and refer members with social determinants of health needs.

Member-Focused 2023 Interventions

- Mailed educational brochures of the referral process for members to community services and resources.

Table 95: Senior Whole Health's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	0.00%	89.71%	75.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	84.90%	88.96%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	20.30%	18.07%	48.80%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.20%	15.52%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	87.50%	88.89%	87.50%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 96: Senior Whole Health Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	81%	83%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	98%	100%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	84%	88%	78%
Pneumococcal Vaccination	Not Available	83%	89%	80%
COVID-19 Vaccination ³	Not Available	Not Available	93%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 97: Senior Whole Health Medicaid Advantage Plus Network Gaps, Quarter 4 2023

Senior Whole Health Medicaid Advantage Plus Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	3	
Fiscal Intermediary	1	
Home Delivered and Congregate Meals	1	
Opioid Treatment Program	8	1
Social Day Care	1	2
Telehealth	7	2

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Senior Whole Health’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 98: Senior Whole Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Whole Health’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Senior Whole Health demonstrated improvement between measurement years 2022 and 2023. Two performance improvement indicator rates exceeded Senior Whole Health’s 2023 target rates while a third reached the target rate.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Senior Whole Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Senior Whole Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Senior Whole Health demonstrated a decline between measurement years 2022 and 2023. The same indicator did not reach Senior Whole Health's 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Senior Whole Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Whole Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Senior Whole Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	outcomes. To address this, Senior Whole Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Senior Whole Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Senior Whole Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Senior Whole Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 99: VillageCare’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	VillageCare Medicaid Advantage Plus’s Response	IPRO’S Assessment of VNS Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VillageCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>VillageCare continues to monitor the Social Determinants of Health performance improvement project. VillageCare is working to develop a Health Equity Subcommittee of the Quality Management Improvement Committee. The Health Equity Subcommittee will use data from the Social Determinants of Health assessments, as well as other sources of data to identify health disparities. The subcommittee will increase awareness of the significance of health disparities and work to drive improvement toward health equity for our members.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>VillageCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.</p>	<p>VillageCare has leveraged the findings from the Department of Health's analysis to inform our internal Quality Assurance and Performance Improvement Program. We have set new initiatives to target risk areas for improvement. Initiatives include Home Care Agency and Care Manager report cards that highlight both strength and risk areas with respect to the Quality Incentives Measure Program and Member Satisfaction. Corrective action will be implemented when necessary to mitigate risk.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	VillageCare Medicaid Advantage Plus's Response	IPRO'S Assessment of VNS Health's Response
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
<p>VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>VillageCare's Quality Management Department continues to utilize its Quality Management Program and Workplan which outlines the required standards and metrics for the Managed Long-Term Care program. In addition, the Quality Management program and workplan identify the stakeholders responsible for ensuring compliance with the standards. The metrics are reported to the Quality Management Improvement Committee quarterly. When goals are not met, a corrective action plan is required, and the Quality Management Department follows the corrective action plan through to resolution.</p>	<p>Addressed.</p>

Performance Improvement Project Summaries and Results

Table 100: VillageCare's Performance Improvement Project Summary, 2023

VillageCare's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p>
<p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p>
<p>Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ VillageCare aims to increase stand-alone completed social determinants of health assessments for all members, both newly enrolled and continuously enrolled. ▪ VillageCare aims to increase the percentage of care manager contacts where social determinants of health assessments is conducted and decrease the number of positive social determinants of health assessments. ▪ VillageCare aims to increase the number of members with positive social determinants of health assessments who have documented intervention(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Provided interpretation resources for social determinants of health assessment to members with a language barrier. ▪ Developed educational tools for care managers related to social determinants of health. ▪ Trained care managers on the social determinants of health assessments and community-based organization information.

Table 101: VillageCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	89.13%	90.35%	≥90%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	12.63%	73.73%	≥90%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	31.74%	6.49%	≥50%
Percentage of members with a positive social determinants of health assessment	No Data To Report	34.82%	15.98%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	9.60%	69.35%	≥90%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 102: VillageCare Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	86%	84%	68%
No Severe Daily Pain	Not Available	100%	98%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	82%	80%	78%
Pneumococcal Vaccination	Not Available	81%	80%	80%
COVID-19 Vaccination ³	Not Available	Not Available	73%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 103: VillageCare Medicaid Advantage Plus Network Gaps, Quarter 4 2023

VillageCare Medicaid Advantage Plus Network Gaps Quarter 4 2023	
Provider Type With A Gap ¹	Gap Type
	County Choice
Medically Supervised Detox Services – Outpatient	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 104: VillageCare’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	VillageCare Measurement Year 2021	VillageCare Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	91%	74%	82%
Rating of Dentist	65%	70%	72%
Rating of Care Manager	86%	92%	87%
Rating of Regular Visiting Nurse	77%	86%	84%
Rating of Home Health Aide	94%	92%	93%
Rating of Transportation Services	69%	80%	72%
Timeliness of Home Health Aide	97%	95%	95%
Timeliness Composite	83%	87%	85%
Involved in Decisions	85%	84%	84%
Manage Illness	91%	85%	85%
Access to Routine Dental Care	28%	36%	35%
Same Day Urgent Dental Care	26%	29%	26%
Plan Asked to See Medicines	92%	91%	93%
Talked About Appointing for Health Decisions	73%	65%	74%
Document Appointing for Health Decisions	57%	45%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	82%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 105: VillageCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VillageCare’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by VillageCare demonstrated improvement between measurement years 2022 and 2023. One performance improvement indicator rate reached VillageCare’s target rate.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Three performance measure rates calculated by the Department of Health for VillageCare for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	VillageCare met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	VillageCare performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by VillageCare demonstrated a decline between measurement years 2022 and 2023. Three performance improvement indicators did not reach VillageCare's 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	VillageCare has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	VillageCare performed significantly worse than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VillageCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	VillageCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, VillageCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended VillageCare pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	VillageCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 106: VNS Health’s Response to the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	VNS Health’s Response	IPRO’S Assessment of VNS Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VNS Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>VNS Health monitors performance improvement project interventions for continuous quality improvement. Care management workflows now include an annual social determinants of health assessment and embedded social determinants of health questions in call scripts for regular follow-up. VNS Health provides education to providers on the importance of social determinants of health screenings and z-codes for ongoing monitoring and linkage. VNS Health’s community center collaborates with providers to offer culturally relevant health education and resources for social determinants of health, including food and financial assistance.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>VNS Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.</p>	<p>VNS Health monitors its performance across the quality measures through real-time dashboards. Linear regression models are used to determine benchmarks which inform measure-level goals that are included in the annual quality workplan. VNS Health reviews performance and initiatives on a weekly basis. When performance falls below the statewide average, VNS Health develops and implements specific interventions to address the</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	VNS Health's Response	IPRO'S Assessment of VNS Health's Response
	measure to improve the performance.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
VNS Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Starting in 2021, VNS Health implemented strategies for continued oversight and ongoing monitoring for alignment with Department of Health requirements. Dashboards are used weekly and/or monthly, for tracking and validation of metrics. Regular audits occur to review service request determination timeliness, consumer-directed personal assistance services orders, and claims and service utilization, to ensure accuracy and maintain timeframes determined by the Department of Health.	Addressed.

Performance Improvement Project Summaries and Results

Table 107: VNS Health's Performance Improvement Project Summary, 2023

VNS Health's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Medicaid Advantage Plus Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ VNS Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ VNS Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ VNS Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ VNS Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Educated the care management team on Healthify, which provides resources available to aid care managers in linking members to community resources and services not covered by VNS Health. ▪ Educated the care management team on the appropriate use of the enhanced social determinants of health assessment and follow-up workflow procedures.

VNS Health’s Performance Improvement Project Summary

- Audited a sample of member records to track care management documentation of community-based referrals for services to address social determinants of health needs.
- VNS Health will monitor and track provider usage of ICD10 Z-Codes for members who screened positive for social determinants of health.
- VNS Health will track percent of in-patient hospital authorizations of diabetic members, who screen positive for social determinants of health.

Member-Focused 2023 Interventions

- Referred members with diabetes and a positive social determinants of health assessments for home delivered meals.
- Published an article on social determinants of health in the member newsletter.
- Care managers will provide telephonic diabetes management and nutrition education to members.

Provider-Focused 2023 Interventions

- Conducted an online course educating provider attendees on Total Over the Counter card and grocery benefits.
- Published a social determinants of health newsletter for providers.

Table 108: VNS Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	21.90%	42.75%	85.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	72.18%	84.57%	80.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	7.80%	15.88%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	9.67%	14.39%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	56.50%	91.60%	65.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 109: VNS Health Medicaid Advantage Plus Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	91%	88%	68%
No Severe Daily Pain	Not Available	100%	98%	96%
Pain Controlled	Not Available	98%	98%	98%
Not Lonely or Not Distressed	Not Available	100%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	81%	85%	78%
Pneumococcal Vaccination	Not Available	86%	91%	80%
COVID-19 Vaccination ³	Not Available	Not Available	88%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Managed Care Operational Survey compliance results are not available for the period under review.

Network Adequacy Results

Table 110: VNS Health Medicaid Advantage Plus Network Gaps, Quarter 4 2023

VNS Health Medicaid Advantage Plus Network Gaps Quarter 4 2023				
Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Adult Day Health Care	2	1	2	
Audiology Services	1			
Fiscal Intermediary	2			
Institutional Long Term Care		1		
Institutional Long Term Care (Vent Skilled Nursing Facility)	1			
Institutional Short Term Care		1		
Licensed Home Health Care: Home Based Medical Social Services	1			
Licensed Home Health Care: Home Based Occupational Therapy		1		
Licensed Home Health Care: Home Based Physical Therapy		1		
Licensed Home Health Care: Home Based Speech Therapy		3		
Moving Assistance		1		
Opioid Treatment Program		1		
Oral Surgery	1	1		
Podiatry	1	1		
Social Day Care			1	2
Telehealth	3	1		

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 111: VNS Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	VNS Health Measurement Year 2021	VNS Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	95%	87%	82%
Rating of Dentist	69%	71%	72%
Rating of Care Manager	85%	87%	87%
Rating of Regular Visiting Nurse	83%	85%	84%
Rating of Home Health Aide	93%	92%	93%
Rating of Transportation Services	71%	59%	72%
Timeliness of Home Health Aide	95%	97%	95%
Timeliness Composite	81%	83%	85%
Involved in Decisions	70%	85%	84%
Manage Illness	90%	86%	85%
Access to Routine Dental Care	29%	34%	35%
Same Day Urgent Dental Care	39%	31%	26%
Plan Asked to See Medicines	94%	94%	93%
Talked About Appointing for Health Decisions	77%	86%	74%
Document Appointing for Health Decisions	66%	80%	61%
Plan Has Document Appointing for Health Decisions	86%	92%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 112: VNS Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VNS Health’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by VNS Health demonstrated improvement between measurement years 2022 and 2023. Two performance improvement indicators exceeded VNS Health’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Six performance measure rates calculated by the Department of Health for VNS Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	VNS Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	VNS Health performed significantly better than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Two performance improvement project indicators did not reach VNS Health's 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	VNS Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	VNS Health performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VNS Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	VNS Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, VNS Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	VNS Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended VNS Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	VNS Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Partial Capitation Managed Long-Term Care Plans

Aetna	194
ArchCare	202
Centers Plan	210
Elderplan.....	219
Elderwood.....	229
Empire BCBS HealthPlus.....	237
EverCare	245
Extended MLTC	252
Fallon Health	258
Fidelis Care	264
Hamaspik	272
iCircle	281
Kalos Health	290
MetroPlus	298
Montefiore.....	307
Nascentia	314
Prime Health	323
RiverSpring.....	332
Senior Health Partners.....	341
Senior Network Health.....	350
Senior Whole Health.....	357
VillageCare	365
VNS Health	374

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 113: Aetna’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Aetna’s Response	IPRO’S Assessment of Aetna’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Aetna should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Aetna diligently monitors its performance improvement projects to help ensure its maintenance and improvement over time. Aetna reviews its actions to ensure the implemented interventions are the most effective in achieving the desired results. As such, the RxDiet Food Farmacy Pilot program which addressed member food insecurity needs will continue as an ongoing program with limited expansion. Aetna remains dedicated to enhancing the project outcomes to meet and sustain identified goals.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>Aetna should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Aetna should focus on enhancing areas of care where its rates are below</p>	<p>Aetna utilizes the Department of Health’s plan analysis findings to define and drive the annual quality assurance and performance improvement program. Aetna is committed to improving unfavorable health outcomes through continuous data review and enhanced processes and procedures. Monthly care management outreach assesses member pain and loneliness status with referrals and follow-ups as needed, in addition to providing member-specific education to</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Aetna's Response	IPRO'S Assessment of Aetna's Response
the Medicaid Managed Long-term Care program mean.	address care gaps in underperforming areas.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Aetna should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Aetna should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Aetna maintains rigorous compliance monitoring with Medicaid standards, implementing processes to manage requirement reviews. Aetna conducts ongoing progress assessments before Department of Health reviews. Aetna's annual compliance plan has been expanded to incorporate external quality review technical report findings, ensuring alignment with contractual requirements. This has been helpful in ensuring readiness for the next survey.	Addressed.

Performance Improvement Project Summaries and Results

Table 114: Aetna's Managed Long-Term Care Plan Performance Improvement Project Summary, 2023

Aetna's Managed Long-Term Care Plan Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Aetna aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Aetna aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Aetna aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Aetna aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Implemented Care Management staff focused education surrounding social determinants of health screening. ▪ Informed care management staff on community-based organizations and resources for social determinants of health. ▪ Incorporated social determinants of health resources into Aetna's care management platform.

Aetna's Managed Long-Term Care Plan Performance Improvement Project Summary

Member-Focused 2023 Interventions

- Educated members on the components of social determinants of health during quarterly Member Advisory Committee meetings.
- Conducted quarterly outreach via telephone to provide member education on social determinants of health, including available programs and benefits.
- Distributed a quarterly Newsletters to members will include information on available community resources and relevant covered benefits pertaining to social determinants of health.
- Completed a three-month, 12-week pilot with RxDiet - a virtual food pharmacy program to 60 selected Asian community members.

Table 115: Aetna's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	45.15%	65.90%	60.26%	76.75%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	6.65%	8.09%	11.08%	9.98%
Percentage of care manager contacts where a social determinants of health screen is conducted	0.00%	0.01%	19.95%	0.10%
Percentage of members with a positive social determinants of health assessment	69.95%	73.04%	74.94%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	79.77%	89.39%	96.22%	95.72%

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 116: Aetna Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	87%	86%	68%
No Severe Daily Pain	Not Available	97%	98%	96%
Pain Controlled	Not Available	97%	98%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	81%	82%	78%
Pneumococcal Vaccination	Not Available	82%	83%	80%
COVID-19 Vaccination ³	Not Available	Not Available	83%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 117: Aetna's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	NC	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 118: Aetna’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Aetna failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 119: Aetna Partial Capitation Network Gaps, Quarter 4 2023

Aetna Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	1	
Institutional Long Term Care (AIDS Skilled Nursing Facility)	2	2
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	1
Institutional Short Term Care	1	
Therapy: Occupational		1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 120: Aetna’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Aetna Measurement Year 2021	Aetna Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	97%	78%	82%
Rating of Dentist	81%	69%	72%
Rating of Care Manager	93%	88%	87%
Rating of Regular Visiting Nurse	84%	86%	84%
Rating of Home Health Aide	97%	92%	93%
Rating of Transportation Services	88%	78%	72%
Timeliness of Home Health Aide	97%	95%	95%
Timeliness Composite	90%	87%	85%
Involved in Decisions	84%	88%	84%
Manage Illness	84%	88%	85%
Access to Routine Dental Care	33%	23%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	16%	26%
Plan Asked to See Medicines	94%	96%	93%
Talked About Appointing for Health Decisions	65%	77%	74%
Document Appointing for Health Decisions	62%	70%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	86%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 121: Aetna’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Aetna’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Aetna demonstrated improvement between measurement years 2022 and 2023. Two performance improvement indicator rates exceeded Aetna’s 2023 target	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	rate, while a third reached the 2023 targeted rate.			
Performance Measures	Six performance measure rates calculated by the Department of Health for Aetna for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Aetna met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Aetna performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Aetna demonstrated a decline between measurement years 2022 and 2023. The same performance improvement indicator rate did not reach Aetna's 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 review, Aetna was not in full compliance with one standard of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Aetna has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Aetna performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Aetna should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Aetna should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Aetna should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Aetna should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Aetna should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Aetna pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Aetna should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 122: ArchCare’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	ArchCare’s Response	IPRO’S Assessment of ArchCare’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, ArchCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Since the execution of the social determinant of health performance improvement project, ArchCare has implemented an assessment tool, education, and reporting that support the actionable utilization of social determinants of health data, which drive initiatives and interventions. Participants have access to a food card and healthy produce programs which are utilized to improve follow-up after a positive screen. To date, ArchCare continues to exceed the targeted goal of conducting social determinants of health screenings for 75% of all enrolled participants.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>ArchCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ArchCare should focus on enhancing areas of care where its rates are</p>	<p>ArchCare has a quality improvement program with multiple strategies to address low performance measures and the barriers that drive low performance. Gaps-in-care reports are reviewed and discussed in Quality Assurance Committee meetings and Quality Improvement Workgroups. Rates are monitored to ensure improvement efforts are succeeding as evidenced in the 2022 external quality review, whereby ArchCare exceeded statewide benchmarks. As interventions prove effective,</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	ArchCare's Response	IPRO'S Assessment of ArchCare's Response
below the Medicaid Managed Long-term Care program mean.	workflows are established for maintaining person-centered care and performance.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
ArchCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	ArchCare has developed a Quality Assurance and Compliance Program to ensure that they are meeting quality standards, federal, and state regulations. The Quality Assurance Committee meets quarterly to discuss issues and potential resolutions. An interdisciplinary approach is used to include compliance oversight and to stay apprised of any regulatory changes. Internal reviews are steered as ArchCare prepares for the compliance review conducted by the Centers for Medicare and Medicaid Services.	Addressed.

Performance Improvement Project Summaries and Results

Table 123: ArchCare's Managed Long-Term Care Plan Performance Improvement Project Summary, 2023

ArchCare's Managed Long-Term Care Plan Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aim</u></p> <ul style="list-style-type: none"> ▪ ArchCare aims to increase screening and follow-up related to social determinants of health disparities for all active, community-based managed long-term care members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Conducted quarterly training to educate staff regarding the prevalence and health impacts of social determinants of health. ▪ Created a process for system-generated reports to allow care managers to view member screenings for social determinants of health within the past month. ▪ Implemented a monthly review by clinical managers on 5% of positive social determinants of health screenings to validate appropriate intervention selection.

Table 124: ArchCare’s Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	45.45%	69.66%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	83.04%	95.64%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	53.47%	40.16%	70.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	13.86%	13.06%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	64.89%	64.67%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 125: ArchCare Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	84%	81%	68%
No Severe Daily Pain	Not Available	99%	95%	96%
Pain Controlled	Not Available	98%	97%	98%
Not Lonely or Not Distressed	Not Available	99%	98%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	75%	72%	78%
Pneumococcal Vaccination	Not Available	76%	66%	80%
COVID-19 Vaccination ³	Not Available	Not Available	79%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 126: ArchCare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2019-2020 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2019-2020 Comprehensive	2023 Focused ¹
438.228: Grievance and Appeal System	NC	
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 127: ArchCare’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
ArchCare failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 128: ArchCare Partial Capitation Network Gaps, Quarter 4 2023

ArchCare Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Institutional Long Term Care		1
Therapy: Speech and Language	1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 129: ArchCare’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	ArchCare Measurement Year 2021	ArchCare Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	84%	82%	82%
Rating of Dentist	72%	75%	72%
Rating of Care Manager	88%	80%	87%
Rating of Regular Visiting Nurse	80%	83%	84%
Rating of Home Health Aide	97%	100%	93%
Rating of Transportation Services	78%	67%	72%
Timeliness of Home Health Aide	94%	98%	95%
Timeliness Composite	82%	81%	85%
Involved in Decisions	70%	76%	84%
Manage Illness	87%	84%	85%
Access to Routine Dental Care	44%	39%	35%
Same Day Urgent Dental Care	23%	18%	26%
Plan Asked to See Medicines	94%	91%	93%
Talked About Appointing for Health Decisions	76%	72%	74%
Document Appointing for Health Decisions	81%	64%	61%
Plan Has Document Appointing for Health Decisions	91%	89%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 130: ArchCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ArchCare’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by ArchCare demonstrated improvement and one remained static between measurement years 2022 and 2023. Two performance improvement indicator rates exceeded ArchCare’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Two performance measure rates calculated by the Department of Health for ArchCare for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	ArchCare met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	ArchCare performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by ArchCare demonstrated a decline between measurement years 2022 and 2023. Two performance improvement indicator rates did not reach ArchCare's 2023 target rate.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for ArchCare for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, ArchCare was not in full compliance with one standard of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	ArchCare has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	ArchCare performed significantly worse than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ArchCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	ArchCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ArchCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	ArchCare should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. ArchCare should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended ArchCare pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	ArchCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Centers Plan

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 131: Center Plan’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Centers Plan’s Response	IPRO’S Assessment of Centers Plan’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Centers Plan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Centers Plan implemented the performance improvement project Searching for Health Equity through the identification of social determinants of health in 2022. Progress was monitored on a monthly basis and Centers Plan met the goal of screening members at a rate greater than 90%. Centers Plan successfully launched and educated care managers on the social determinants of health screening tool in the care manager software. The impact of the intervention was monitored, and member refusal due to time constraints was identified as a main barrier. The barrier was addressed by prioritizing the social determinants of health screening and intervention in each member contact.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>Centers Plan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced</p>	<p>Centers Plan’s managed long-term care plan barely met the statewide average for preventative screenings, including vision and hearing exams. To address this gap, the managed long-term care management team renewed efforts to increase education on the importance of preventive screenings and offer assistance to schedule appointments. The team also offered assistance in</p>	<p>Remains an Opportunity for Improvement.</p>

2022 External Quality Review Recommendation	Centers Plan's Response	IPRO'S Assessment of Centers Plan's Response
unfavorable health outcomes. To address this, Centers Plan should focus on enhancing areas of care where their rates are below the Medicaid Managed Long-term Care program mean.	coordinating transportation to and from the appointment, and by exploring the option for in-home provider visits for members who are homebound.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Centers Plan should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Centers Plan should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	As outlined in the Department of Health 2021 Survey Statement of Deficiencies, there were seven areas found to be in need of correction. Some of the findings identified were isolated incidents of non-compliance or related to historical plan processes that had been addressed prior to the survey findings; however, to ensure ongoing compliance, Centers Plan has executed the state-approved plan of correction and continues to conduct routine monitoring to ensure compliance is achieved and maintained.	Addressed.

Performance Improvement Project Summaries and Results

Table 132: Centers Plan's Managed Long-Term Care Plan Performance Improvement Project Summary, 2023

Centers Plan's Managed Long-Term Care Plan Performance Improvement Project Summary
Title: Searching for Health Equity through Identification of Social Determinants of Health
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aim</u></p> <ul style="list-style-type: none"> Centers Plan aims to complete a social determinants of health assessment for new and continuing enrollees, and improve the documentation of referrals and follow-up made for members at-risk for social determinants of health needs. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Conducted care management training for all staff. Utilized automated reports within the care management system to track social determinants of health assessment indicators. Created a comprehensive referral list for care management use based on social determinants of health needs.

Table 133: Centers Plan’s Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	94.36%	95.46%	40.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	96.84%	99.39%	40.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	50.60%	92.33%	28.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.71%	3.79%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	83.34%	82.48%	60.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 134: Centers Plan Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	49%	46%	68%
No Severe Daily Pain	Not Available	87%	86%	96%
Pain Controlled	Not Available	98%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	78%	79%	78%
Pneumococcal Vaccination	Not Available	86%	88%	80%
COVID-19 Vaccination ³	Not Available	Not Available	52%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 135: Centers Plan’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	C	
438.210: Coverage and Authorization of Services	C	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	NC	
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 136: Centers Plan’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Centers Plan failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 137: Centers Plan Partial Capitation Network Gaps, Quarter 4 2023

Centers Plan Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care		2
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	1
Institutional Long Term Care (Vent Skilled Nursing Facility)		1
Oral Surgery	1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 138: Centers Plan’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Centers Plan Measurement Year 2021	Centers Plan Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	94%	74%	82%
Rating of Dentist	71%	82%	72%
Rating of Care Manager	94%	84%	87%
Rating of Regular Visiting Nurse	91%	85%	84%
Rating of Home Health Aide	99%	94%	93%
Rating of Transportation Services	61%	72%	72%
Timeliness of Home Health Aide	96%	95%	95%
Timeliness Composite	83%	89%	85%
Involved in Decisions	82%	80%	84%
Manage Illness	83%	83%	85%
Access to Routine Dental Care	24%	32%	35%
Same Day Urgent Dental Care	19%	24%	26%
Plan Asked to See Medicines	90%	97%	93%
Talked About Appointing for Health Decisions	79%	74%	74%
Document Appointing for Health Decisions	63%	61%	61%
Plan Has Document Appointing for Health Decisions	79%	84%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 139: Centers Plan’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Centers Plan’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Centers Plan demonstrated improvement and one of four performance improvement indicator rates remained static between measurement years 2022 and 2023. All four performance improvement indicator rates exceeded Centers Plan’s 2023 target rates.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Centers Plan for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Centers Plan met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Centers Plan performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Centers Plan for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Centers Plan was not in full compliance with one standard of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Centers Plan has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	Centers Plan performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Centers Plan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Centers Plan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Centers Plan should focus on enhancing areas of care where their rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Centers Plan should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Centers Plan should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Centers Plan pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Centers Plan should evaluate member satisfaction and address adverse member	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	experience with areas linked to quality, timeliness, and access to care.			

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 140: Elderplan’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Elderplan’s Response	IPRO’S Assessment of Elderplan’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Elderplan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Elderplan exceeded project goals of social determinant of health screening completion and care management contact; Elderplan continues to complete social determinants of health assessments with every care planning call to identify social barriers and risks, implementing appropriate interventions to address them. A social work coordinator was hired in 2023 to ensure that targeted interventions are continuously developed and followed up on. Ongoing education is provided to all care management staff to ensure members’ needs are met and outcomes are properly monitored.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>Elderplan should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderplan should focus on enhancing areas of care where its rates are</p>	<p>Elderplan members are frail and medically complex, with self-reported health status significantly below the statewide average. In 2023, Elderplan focused on preventing worsened shortness of breath through disease management and transitions of care programs, community-based organization partnerships for home visits post-acute episode, referrals to certified home health agencies, and ongoing member education on disease progression. Elderplan uses plan-do-study-act methodology to determine program effectiveness,</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Elderplan's Response	IPRO'S Assessment of Elderplan's Response
below the Medicaid Managed Long-term Care program mean.	with health fairs and the home visiting nurse practitioner program showing 7% improvement in flu vaccination rates.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Elderplan implemented corrective actions to address deficiency with training pertaining to policy and procedures on fair hearing processing; system updates included evidence packet mail date reminders and daily reports sent to appeals and grievance management to monitor the status of cases with any evidence packets pending mailing. Any anomalies were escalated and reported to the compliance department. Elderplan conducts routine monitoring and auditing, keeping policies and procedures up to date with federal and state requirements.	Addressed.

Performance Improvement Project Summaries and Results

Table 141: Elderplan’s Performance Improvement Project Summary, 2023

Elderplan’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none">▪ Elderplan aims to increase the percentage of members with social determinants of health assessments among new and continuously enrolled members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Enhanced annual training program to include social determinants of health tool and available community resources.▪ Distributed an updated workflow that includes a requirement to complete the social determinants of health screening tool at least once a year to care management staff. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Developed individualized care plans with targeted interventions for members with needs by the social determinants of health tool.

Table 142: Elderplan’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	98.27%	98.96%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	99.45%	99.61%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	8.97%	21.32%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	62.29%	43.27%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 143: Elderplan Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	48%	47%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	73%	78%	78%
Pneumococcal Vaccination	Not Available	79%	81%	80%
COVID-19 Vaccination ³	Not Available	Not Available	78%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 144: Elderplan’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	C		
438.100: Enrollee Rights	C		NC
438.114: Emergency and Poststabilization Services	C		
438.206: Availability of Services	C	NC	
438.207: Assurances of Adequate Capacity and Services	C		
438.208: Coordination and Continuity of Care	NC		
438.210: Coverage and Authorization of Services	NC		NC
438.214: Provider Selection	C		
438.224: Confidentiality	C		
438.228: Grievance and Appeal System	C		
438.230: Subcontractual Relationships and Delegation	C		
438.236: Practice Guidelines	C		
438.242: Health Information Systems	C		
438.330: Quality Assessment and Performance Improvement Program	C		

¹ Provider Network Delivery System Focused Survey.

² Social Day Care Reduction Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 145: Elderplan’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
2023 Comprehensive Survey Findings		
Nine records lacked evidence of monthly contact with the member.	Managed Long-Term Care Partial Capitation Contract Article V J.6.a.	438.208
For two prior authorization or concurrent reviews following a service request, no evidence was provided that Elderplan notified the enrollee of the decision in writing within the required timeframe.	Managed Long-Term Care Partial Capitation Contract Appendix K	438.210
2023 Provider Network Delivery System Focused Survey Findings		
Elderplan failed to meet the minimum requirements for Network Adequacy for required Managed Long Term Care services.	Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206
2023 Social Day Care Reduction Focused Survey Findings		
Elderplan failed to assist the member in achieving outcomes they define for themselves, and in the most integrated community setting(s) they desire.	Managed Long Term Care Partial Capitation Contract Article V J.9.c.iv.	438.210 438.100
Adverse Determination notices sent to members for the reduction of Social Day Care did not identify a specific change or circumstance that supported the reduction and was not based on the member’s specific needs and preferences.	Managed Long Term Care Partial Capitation Contract Appendix K Managed Long Term Care Policy 16.06 18 NYCRR 360-10.8(e)(2)(i)(b)	438.210

Network Adequacy Results

Table 146: Elderplan Partial Capitation Network Gaps, Quarter 4 2023

Elderplan Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	2	2
Audiology Services	2	1
Institutional Long Term Care (AIDS Skilled Nursing Facility)		1
Optometry	1	
Oral Surgery	2	1
Podiatry		1
Social Day Care	2	4

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network .

Quality-of-Care Survey Results – Member Experience

Table 147: Elderplan’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Elderplan Measurement Year 2021	Elderplan Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	94%	82%	82%
Rating of Dentist	78%	72%	72%
Rating of Care Manager	93%	91%	87%
Rating of Regular Visiting Nurse	91%	84%	84%
Rating of Home Health Aide	94%	96%	93%
Rating of Transportation Services	79%	71%	72%
Timeliness of Home Health Aide	95%	98%	95%
Timeliness Composite	86%	86%	85%
Involved in Decisions	86%	87%	84%
Manage Illness	86%	87%	85%
Access to Routine Dental Care	38%	33%	35%
Same Day Urgent Dental Care	30%	23%	26%
Plan Asked to See Medicines	94%	94%	93%
Talked About Appointing for Health Decisions	78%	79%	74%
Document Appointing for Health Decisions	55%	71%	61%
Plan Has Document Appointing for Health Decisions	79%	87%	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 148: Elderplan’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderplan’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Elderplan remained static between measurement years 2022 and 2023. All four performance improvement indicator rates exceeded Elderplan’s 2023 target rates.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Elderplan for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, Elderplan was in compliance with 12 standards of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	Elderplan met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Elderplan performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Elderplan demonstrated a decline between measurement years 2022 and 2023.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Elderplan for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	Elderplan was not in full compliance with two standards of <i>42 Code of Federal Regulations Part 438 Subpart D in the comprehensive review</i> .	X	X	X
Network Adequacy	Elderplan has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Elderplan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Elderplan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderplan should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Elderplan pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Elderplan should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Elderwood Partial Capitation ceased operations before the production of the 2023 External Quality Review Annual Technical Report. Due to Elderwood Partial Capitation’s departure from the Managed Long-Term Care program, a response could not be obtained.

Performance Improvement Project Summaries and Results

Table 149: Elderwood’s Performance Improvement Project Summary, 2023

Elderwood’s Managed Long-Term Care Plan Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none">▪ Elderwood aims to improve screening rates and follow-up for social determinants of health needs identified for their membership using clinical and non-clinical interventions. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Trained social workers on prevalence and health impacts of social determinants of health, particularly among the managed long-term care population, and how to utilize the “Tools for Action” on the Healthy People 2030 website.▪ Utilized updated Case Management system to ensure that the workflow for screening/and interventions applied for eligible population is conducted by assigned care management staff.▪ Held bi-weekly meetings with care management system vendor to support tracking initiatives to improve efficiencies of data collection and accurate report delivery as social determinants of health data migrates from spreadsheet tracking to the care management system.▪ Improved tracking of communication efforts between the social worker conducting the social determinants of health assessment and the primary care manager of that member to increase follow-up and rapport between assessor and primary care manager.

Table 150: Elderwood’s Performance Improvement Project Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	81.04%	80.37%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	83.17%	67.11%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	12.14%	13.34%	20.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	32.42%	41.18%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	30.77%	93.41%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 151: Elderwood Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	47%	50%	68%
No Severe Daily Pain	Not Available	96%	95%	96%
Pain Controlled	Not Available	92%	89%	98%
Not Lonely or Not Distressed	Not Available	88%	89%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	65%	68%	78%
Pneumococcal Vaccination	Not Available	68%	64%	80%
COVID-19 Vaccination ³	Not Available	Not Available	73%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 152: Elderwood's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	C	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	
438.230: Subcontractual Relationships and Delegation	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 153: Elderwood’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
2023 Comprehensive Survey Findings		
Elderwood failed to provide evidence that monitoring of providers is performed for Fiscal Intermediaries.	Managed Long Term Care Contract Article V11 A.1 Article VII C. 1 Article II E.	438.206
Of those records that indicated the enrollee is receiving Consumer Directed Personal Assistance Services, eight did not contain a compliant physician’s order and/or Consumer Directed Personal Assistance Services responsibilities form.	Title 18 New York Code of Rules and Regulations 505.28 (d)(1)(i-iv) 505.28 (f)(1)"	438.208
Twenty-two records lacked evidence of monthly contact with the member.	Managed Long Term Care Partial Capitation Contract Article V J.6.a.	438.208
For two prior authorization or concurrent reviews following a service request, the plan inappropriately issued multiple extension notices to enrollees.	Managed Long Term Care Partial Capitation Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements	438.210
For two prior authorization or concurrent reviews following a service request, no evidence was provided that the decision was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements	438.210
Five records submitted for review contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment, contain the proposed date of enrollment, or signed by the enrollee.	Managed Long Term Care Partial Capitation Contract Article V C. 1 Article V H. 5	438.242
2023 Provider Network Delivery System Focused Survey Findings		

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
2023 Comprehensive Survey Findings		
Elderwood failed to provide evidence that monitoring of providers is performed for Fiscal Intermediaries.	Managed Long Term Care Contract Article V11 A.1 Article VII C. 1 Article II E.	438.206
Of those records that indicated the enrollee is receiving Consumer Directed Personal Assistance Services, eight did not contain a compliant physician's order and/or Consumer Directed Personal Assistance Services responsibilities form.	Title 18 New York Code of Rules and Regulations 505.28 (d)(1)(i-iv) 505.28 (f)(1)"	438.208
Twenty-two records lacked evidence of monthly contact with the member.	Managed Long Term Care Partial Capitation Contract Article V J.6.a.	438.208
For two prior authorization or concurrent reviews following a service request, the plan inappropriately issued multiple extension notices to enrollees.	Managed Long Term Care Partial Capitation Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements	438.210
For two prior authorization or concurrent reviews following a service request, no evidence was provided that the decision was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements	438.210
Five records submitted for review contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment, contain the proposed date of enrollment, or signed by the enrollee.	Managed Long Term Care Partial Capitation Contract Article V C. 1 Article V H. 5	438.242
Elderwood failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 154: Elderwood Partial Capitation Network Gaps, Quarter 4 2023

Elderwood Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Social Day Care	1	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 155: Elderwood’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Elderwood Measurement Year 2021	Elderwood Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	99%	88%	82%
Rating of Dentist	81%	71%	72%
Rating of Care Manager	93%	90%	87%
Rating of Regular Visiting Nurse	91%	86%	84%
Rating of Home Health Aide	93%	95%	93%
Rating of Transportation Services	79%	78%	72%
Timeliness of Home Health Aide	99%	97%	95%
Timeliness Composite	88%	85%	85%
Involved in Decisions	91%	88%	84%
Manage Illness	88%	83%	85%
Access to Routine Dental Care	51%	40%	35%
Same Day Urgent Dental Care	23%	23%	26%
Plan Asked to See Medicines	95%	92%	93%
Talked About Appointing for Health Decisions	72%	73%	74%
Document Appointing for Health Decisions	73%	74%	61%
Plan Has Document Appointing for Health Decisions	85%	77%	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 156: Elderwood’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderwood’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Elderwood demonstrated improvement and one remained static between measurement years 2022 and 2023. Two of four performance improvement indicator rates exceeded Elderwood’s 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, Elderwood was in compliance with 10 standards of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	Elderwood met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Elderwood performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Elderwood demonstrated a decline between measurement years 2022 and 2023. Two performance improvement indicator rates did not reach Elderwood’s 2023 target rate.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Elderwood for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Elderwood was not in full compliance with four standards of <i>42 Code of Federal Regulations Part 438 Subpart D</i> during the comprehensive review.	X	X	X
Network Adequacy	Elderwood has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Elderwood should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Elderwood should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderwood should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderwood should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Elderwood pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Elderwood should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Empire BCBS HealthPlus

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 157: Empire BCBS HealthPlus’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Empire BCBS HealthPlus’s Response	IPRO’S Assessment of Empire BCBS HealthPlus’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Empire BCBS HealthPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Both Integra and HealthPlus conducted a performance improvement project to improve social determinants of health screening, achieving all four goals and continue to monitor these performance indicators. As we implement the New York State Medicaid Social Care Initiative to enhance social care services and collaboration between Health-Related Social Needs providers and care managers, the Plan will assess the effectiveness of our interventions to ensure ongoing improvement. We will maintain highly effective interventions and modify or replace those with low impact.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Empire BCBS HealthPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.</p>	<p>The 2022 external quality review by the Department of Health revealed that Empire BCBS HealthPlus and Integra outperformed the statewide Medicaid Managed Long-Term Care Plan average in all performance measures, except for Integra's pneumococcal vaccination rate, which was below average. Consequently, we have implemented performance improvement strategies for this measure, inclusive of cross functional training sessions for staff</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Empire BCBS HealthPlus's Response	IPRO'S Assessment of Empire BCBS HealthPlus's Response
	on best practices. We will continue to monitor progress.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	The New York Medicaid Compliance Committee meets ten times per year and reviews the following: monthly operational scorecard of Medicaid standards; all statements of deficiency and findings received; and results of audits and other oversight. Also, representatives across functional areas assess the impact of state mandates and guidance utilizing the Compliance 360 system; evidence of gap closure is required. Updates are provided to the Quality Management Committee.	Addressed.

Performance Improvement Project Summaries and Results

Table 158: Empire BCBS HealthPlus's Performance Improvement Project Summary, 2023

Empire BCBS HealthPlus's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Empire BCBS HealthPlus aims to increase the percentage of completed social determinants of health screenings and interventions for managed long-term care and fully integrated dual eligible members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Educated staff on the prevalence and health impacts of social determinants of health among the managed long-term care population. ▪ Utilized system-generated reports allowing care managers to monitor and track identified social determinants of health needs and interventions. ▪ Trained care management staff on the social determinants of health screening tool and tracking interventions. <p><u>Member-Focused 2023 Intervention</u></p> <ul style="list-style-type: none"> ▪ Developed and distributed education materials and social determinants of health toolkits for member communication that include local resources and available programs related to social determinants of health.

Empire BCBS HealthPlus's Performance Improvement Project Summary

Provider-Focused 2023 Intervention

- Educated managed long-term care service providers (licensed home care services agencies) on social determinants of health needs and health plan's interventions.

Table 159: Empire BCBS HealthPlus's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement ¹	Interim Measurement ²	Final Measurement ³	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	97.36%	98.47%	98.05%	80.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	85.56%	81.79%	76.25%	80.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	87.65%	84.21%	77.82%	70.00%
Percentage of members with a positive social determinants of health assessment	0.30%	0.30%	0.30%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	19.69%	27.74%	32.02%	33.00%

¹ Due to a merger during the course of the performance improvement plan, the baseline measurement period was December 2022 only.

² Due to a merger during the course of the performance improvement plan, the interim measurement period was January 1st, 2023, to July 31st, 2023.

³ Due to a merger during the course of the performance improvement plan, the final measurement period was August 1st, 2023, to December 31st, 2023.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 160: Empire BCBS HealthPlus Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	88%	74%	68%
No Severe Daily Pain	Not Available	100%	100%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	78%	83%	78%
Pneumococcal Vaccination	Not Available	81%	82%	80%
COVID-19 Vaccination ³	Not Available	Not Available	84%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 161: Empire BCBS HealthPlus Compliance with Federal Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.224: Confidentiality	
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Network Adequacy Results

No gaps in network adequacy were identified for Empire BCBS HealthPlus in Quarter 4 of 2023.

Quality-of-Care Survey Results – Member Experience

Table 162: Empire BCBS HealthPlus’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Empire BCBS HealthPlus Measurement Year 2021	Empire BCBS HealthPlus Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	88%	79%	82%
Rating of Dentist	66%	66%	72%
Rating of Care Manager	92%	92%	87%
Rating of Regular Visiting Nurse	85%	84%	84%
Rating of Home Health Aide	93%	96%	93%
Rating of Transportation Services	81%	68%	72%
Timeliness of Home Health Aide	95%	93%	95%
Timeliness Composite	80%	80%	85%
Involved in Decisions	83%	79%	84%
Manage Illness	87%	85%	85%
Access to Routine Dental Care	46%	33%	35%
Same Day Urgent Dental Care	33%	30%	26%
Plan Asked to See Medicines	93%	93%	93%
Talked About Appointing for Health Decisions	78%	76%	74%
Document Appointing for Health Decisions	66%	55%	61%
Plan Has Document Appointing for Health Decisions	82%	87%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 163: Empire BCBS HealthPlus’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Empire BCBS HealthPlus’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Note that due to a merger during the course of the performance improvement plan, Empire BCBS HealthPlus reported that the reported rates were modified and reflective of a baseline measurement period of December 2022; an interim measurement period of January 1 st , 2023, to July 31 st , 2023; and a final measurement period of August 1 st , 2023, to December 31 st , 2023. One of four performance improvement project indicator rates reported by Empire BCBS HealthPlus demonstrated improvement and one remained static between the modified Interim and Final Measurement periods. One performance improvement project indicator rate met Empire BCBS HealthPlus’s target rates. Two performance improvement rates exceeded Empire BCBS HealthPlus’s 2023 target rates.	X	X	X
Performance Measures	All seven performance measure rates calculated by the Department of Health for Empire BCBS HealthPlus for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus was in compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	Empire BCBS HealthPlus met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Empire BCBS HealthPlus performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Note that due to a merger during the course of the performance improvement plan, Empire BCBS HealthPlus reported that the reported rates were modified and reflective of a baseline measurement period of December 2022; an interim measurement period of January 1 st , 2023, to July 31 st , 2023; and a final measurement period of August 1 st , 2023, to December 31 st , 2023. Two of four performance improvement project indicator rates reported by Empire BCBS HealthPlus demonstrated a decline between the modified Interim and Final measurement periods. Two performance improvement indicator rates did not reach Empire BCBS HealthPlus' 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	None.		X	X
Quality-of-Care Survey	Empire BCBS HealthPlus performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Empire BCBS HealthPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Empire BCBS HealthPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	<p>program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Empire BCBS HealthPlus should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>			
Compliance with Federal Managed Care Standards	<p>Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	X	X	X
Network Adequacy	<p>It is recommended Empire BCBS HealthPlus continue to pursue provider contracts to expand their provider network.</p>		X	X
Quality-of-Care Survey	<p>Empire BCBS HealthPlus should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.</p>	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

EverCare Partial Capitation ceased operations before the production of the 2023 External Quality Review Annual Technical Report. Due to EverCare Partial Capitation’s departure from the Managed Long-Term Care program, a response could not be obtained.

Performance Improvement Project Summaries and Results

Table 164: EverCare’s Performance Improvement Project Summary, 2023

EverCare’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ EverCare aims to improve the rate of completed stand-alone social determinants of health assessments for newly enrolled members. ▪ EverCare aims to improve the rate of completed stand-alone social determinants of health assessments for continuously enrolled members. ▪ EverCare aims to increase the rate of care manager contacts where a screen for social determinants of health is conducted for all members. ▪ EverCare aims to improve the identification of members with social determinants of health needs. ▪ EverCare aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ EverCare aims to increase the percentage of members identified with a positive social determinants of health assessment and have documented interventions to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Trained care managers on social determinants of health including appropriate implications, screening tools, community organizations/resources, covered benefits, prevalence, and health impacts of social determinants of health among the managed long-term care population. ▪ Monitored status of referrals and receipt of service with contracted community-based organizations via monthly case conferencing with community-based organizations. ▪ Monitored and tracked members with social determinants of health needs to ensure closed-loop referrals to community services and supports. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Monitored status of referrals and receipt of service with non-contracted community-based organizations via monthly call with referred member. ▪ Developed and distributed new member educational materials which included information about available programs and benefits related to social determinants of health.

Table 165: EverCare Choice’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	66.45%	99.52%	75.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	98.35%	86.36%	98.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	80.57%	16.04%	80.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	13.24%	3.89%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	54.70%	62.96%	70.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 166: EverCare Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	72%	66%	68%
No Severe Daily Pain	Not Available	93%	94%	96%
Pain Controlled	Not Available	93%	91%	98%
Not Lonely or Not Distressed	Not Available	97%	97%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	79%	74%	78%
Pneumococcal Vaccination	Not Available	80%	80%	80%
COVID-19 Vaccination ³	Not Available	Not Available	68%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 167: EverCare's Compliance with Federal Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	NC	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	C	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 168: EverCare’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
EverCare failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 169: Evercare Partial Capitation Network Gaps, Quarter 4 2023

Evercare Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	1	
Licensed Home Health Care: Home Based Occupational Therapy	3	
Licensed Home Health Care: Home Based Physical Therapy		3
Licensed Home Health Care: Home Based Speech Therapy	3	
Optometry	1	1
Social Day Care		2

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 170: EverCare’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	EverCare Measurement Year 2021	EverCare Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	91%	80%	82%
Rating of Dentist	67%	79%	72%
Rating of Care Manager	89%	88%	87%
Rating of Regular Visiting Nurse	79%	92%	84%
Rating of Home Health Aide	95%	88%	93%
Rating of Transportation Services	83%	83%	72%
Timeliness of Home Health Aide	97%	95%	95%
Timeliness Composite	85%	84%	85%
Involved in Decisions	91%	80%	84%
Manage Illness	85%	86%	85%
Access to Routine Dental Care	45%	29%	35%
Same Day Urgent Dental Care	23%	21%	26%
Plan Asked to See Medicines	95%	89%	93%
Talked About Appointing for Health Decisions	78%	69%	74%
Document Appointing for Health Decisions	89%	81%	61%
Plan Has Document Appointing for Health Decisions	92%	82%	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 171: EverCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	EverCare’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by EverCare demonstrated improvement between measurement years 2022 and 2023. One performance improvement indicator exceeded EverCare’s 2023 target rate.	X	X	X
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	EverCare met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	EverCare performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement project indicator rates reported by EverCare demonstrated a decline between measurement years 2022 and 2023. Three performance improvement indicator rates did not reach EverCare's 2023 target rate.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for EverCare for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, EverCare was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	EverCare has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, EverCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	replaced based on the results of a recent barrier analysis.			
Performance Measures	EverCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, EverCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Ever Care should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Ever Care should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended EverCare pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	EverCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Extended MLTC

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Extended MLTC Partial Capitation Plan ceased operations within measurement year 2023. Extended MLTC Partial Capitation Plan was acquired by Hamaspik Choice Partial Capitation Plan on 8/1/2023.

Performance Improvement Project Summaries and Results

Table 172: Extended MLTC’s Performance Improvement Project Summary, 2022

Extended MLTC’s Partial Capitation Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">Extended MLTC aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment.Extended MLTC aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment.Extended MLTC aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted.Extended MLTC aims to decrease the percentage of members with a positive social determinants of health assessment.Extended MLTC aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s).
<p><u>Member-Focused 2022 Intervention</u></p> <ul style="list-style-type: none">Developed and distributed member education materials which included information about available programs and health plan benefits related to social determinants of health.
<p><u>Managed Care Plan-Focused 2022 Interventions</u></p> <ul style="list-style-type: none">Trained care management staff regarding the prevalence and health impacts of social determinants of health among the managed long-term care population, screening process, and recommended interventions to address five social determinants of health domains.Created a new electronic note type for documentation of positive social determinants of health findings in the care management record.Developed a social determinants of health workflow to ensure closed-loop process for implementation of planned care management interventions for all positive social determinants of health findings.

Table 173: Extended MLTC’s Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	92.00%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	94.50%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	47.82%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	4.56%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 174: Extended MLTC Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	69%	71%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	98%	98%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	76%	78%	78%
Pneumococcal Vaccination	Not Available	77%	77%	80%
COVID-19 Vaccination ³	Not Available	Not Available	83%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 175: Extended MLTC’s Compliance with Federal Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 176: Extended MLTC’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Extended MLTC failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Extended MLTC Partial Capitation Plan ceased operations within measurement year 2023 and therefore did not have a network adequacy evaluation performed in quarter four of 2023. Extended MLTC Partial Capitation Plan was acquired by Hamaspik Choice Partial Capitation Plan on 8/1/2023.

Quality-of-Care Survey Results – Member Experience

Table 177: Extended MLTC’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Extended MLTC Measurement Year 2021	Extended MLTC Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	85%	81%	82%
Rating of Dentist	79%	73%	72%
Rating of Care Manager	93%	90%	87%
Rating of Regular Visiting Nurse	93%	86%	84%
Rating of Home Health Aide	93%	95%	93%
Rating of Transportation Services	80%	66%	72%
Timeliness of Home Health Aide	95%	97%	95%
Timeliness Composite	90%	85%	85%
Involved in Decisions	75%	85%	84%
Manage Illness	83%	87%	85%
Access to Routine Dental Care	30%	39%	35%
Same Day Urgent Dental Care	21%	29%	26%
Plan Asked to See Medicines	88%	92%	93%
Talked About Appointing for Health Decisions	55%	70%	74%
Document Appointing for Health Decisions	52%	67%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	73%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 178: Extended MLTC’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Extended MLTC’s performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
	All four performance improvement project indicator rates exceeded targets between measurement years 2021 and 2022.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Five performance measure rates calculated by the Department of Health for Extended MLTC for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for Extended MLTC for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Extended MLTC was not in full compliance with one standard of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project, Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy, Quality-of-Care Survey	Extended MLTC Partial Capitation Plan was acquired by Hamaspik Choice Partial Capitation Plan on 8/1/2023; Extended MLTC is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendations were made.			

Fallon Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Fallon Health MLTC Partial Capitation Plan announced a withdrawal effective 12/31/2023.

Performance Improvement Project Summaries and Results

Table 179: Fallon Health’s Performance Improvement Project Summary, 2023

Fallon Health’s Partial Capitation Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none"> Fallon Health aims to increase screening rates, and follow-up for social determinants of health needs among managed long-term care members using clinical and non-clinical interventions. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Integrated an electronic medical record-generated report to identify members in need of a social determinants of health assessment. Created a tracking tool for SDOH positive screen interventions within the electronic medical record.

Table 180: Fallon Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021 – 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	96.43%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	97.70%	94.48%	97.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	99.63%	99.13%	97.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	50.26%	20.80%	Not Required

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	58.22%	89.71%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 181: Fallon Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	44%	40%	68%
No Severe Daily Pain	Not Available	94%	95%	96%
Pain Controlled	Not Available	86%	90%	98%
Not Lonely or Not Distressed	Not Available	87%	88%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	55%	45%	78%
Pneumococcal Vaccination	Not Available	52%	46%	80%
COVID-19 Vaccination ³	Not Available	Not Available	38%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 182: Fallon Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	C
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Network Adequacy Results

Table 183: Fallon Health Partial Capitation Network Gaps, Quarter 4 2023

Fallon Health Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	1	1
Certified or Licensed Home Health Care – Personal Care Assistant	2	
Fiscal Intermediary	3	1
Home Delivered and Congregate Meals	2	
Institutional Long Term Care (AIDS Skilled Nursing Facility)	2	
Institutional Long Term Care (Vent Skilled Nursing Facility)	2	
Institutional Short Term Care	2	
Licensed Home Health Care: Home Based Medical Social Services	2	
Licensed Home Health Care: Home Based Occupational Therapy	2	
Licensed Home Health Care: Home Based Physical Therapy	2	
Licensed Home Health Care: Home Based Speech Therapy	2	
Certified Home Health: Home Based Medical Social Services		2
Optometry		1
Oral Surgery	1	

Fallon Health Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Social and Environmental Support		1
Telehealth	2	
Therapy: Respiratory	2	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 184: Fallon Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Fallon Health Measurement Year 2021	Fallon Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	89%	92%	82%
Rating of Dentist	75%	81%	72%
Rating of Care Manager	90%	91%	87%
Rating of Regular Visiting Nurse	86%	88%	84%
Rating of Home Health Aide	89%	94%	93%
Rating of Transportation Services	81%	76%	72%
Timeliness of Home Health Aide	93%	93%	95%
Timeliness Composite	78%	89%	85%
Involved in Decisions	86%	87%	84%
Manage Illness	82%	81%	85%
Access to Routine Dental Care	46%	44%	35%
Same Day Urgent Dental Care	15%	24%	26%
Plan Asked to See Medicines	92%	93%	93%
Talked About Appointing for Health Decisions	65%	60%	74%
Document Appointing for Health Decisions	60%	66%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	70%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 185: Fallon Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fallon Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	One of four performance improvement project indicator rates reported by Fallon Health demonstrated improvement and one remained static between measurement years 2022 and 2023. One performance improvement indicator rate exceeded Fallon Health’s 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	Fallon Health was in compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	Fallon Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Fallon Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement project indicator rates reported by Fallon Health demonstrated a decline between measurement years 2022 and 2023. Three performance improvement indicator rates did not reach Fallon Health’s 2023 target rate.	X	X	X
Performance Measures	Six performance measure rates calculated by the Department of Health for Fallon Health for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Fallon Health has the opportunity to reduce their gaps in their network that were identified		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	Fallon Health performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project, Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy, Quality-of-Care Survey	Fallon Health announced a withdrawal effective 12/31/2023; Fallon Health is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendations were made.			

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 186: Fidelis Care’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Fidelis Care’s Response	IPRO’S Assessment of Fidelis Care’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Fidelis Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Fidelis Care continues to progress toward performance improvement through robust management reports and monthly reviews at quality committee meetings. Staff and member education materials are provided regularly regarding the performance improvement project. Fidelis Care continues to assess members’ needs and provide referrals, interventions, and follow-up based on those social determinants of health needs. The improvement projects’ processes and benefits remain in place to date even following the completion of the performance improvement plan.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>Fidelis Care should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically</p>	<p>Fidelis Care conducts regular monitoring of members’ health assessment data. Members with gaps-in-care are identified and encouraged to access care, are offered assistance with appointments, or are offered in-home services where appropriate to promote health and prevent unfavorable outcomes. Fidelis Care has modified its monthly call script and in-</p>	<p>Partially addressed.</p>

2022 External Quality Review Recommendation	Fidelis Care's Response	IPRO'S Assessment of Fidelis Care's Response
<p>signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fidelis Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>home care management visits to enhance positive messaging.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>Fidelis Care has a robust routine monitoring program to ensure that compliance is met with federal and state standards. Fidelis Care conducts semiannual mock survey reviews of a random sample of member records. Results of the mock surveys are reported to Fidelis Care Compliance for review and monitoring.</p>	<p>Addressed.</p>

Performance Improvement Project Summaries and Results

Table 187: Fidelis Care's Performance Improvement Project Summary, 2023

Fidelis Care's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p>
<p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p>
<p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among new enrollees within the first 30 days of enrollment. ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among continuously enrolled members. ▪ Fidelis Care aims to increase the percentage of care manager contacts where a stand-alone social determinants of health screening was conducted. ▪ Fidelis Care aims to increase the percentage of members with documented action taken to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p>

Fidelis Care's Performance Improvement Project Summary

- Updated care management workflow to include member education on the importance of completing assessments.
- Educated staff on the impact of social determinants of health, assessment tools, and resources available.

Member-Focused 2023 Interventions

- Published a member newsletter article on social determinants of health resources.
- Linked members identified with a positive social determinants of health assessment to appropriate resources based on member need.

Table 188: Fidelis Care's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	58.39%	77.57%	70.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	74.54%	84.34%	70.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	84.20%	98.56%	95.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	18.88%	17.79%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	77.68%	96.28%	30.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 189: Fidelis Care Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	76%	73%	68%
No Severe Daily Pain	Not Available	92%	92%	96%
Pain Controlled	Not Available	97%	97%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	67%	66%	78%
Pneumococcal Vaccination	Not Available	65%	66%	80%
COVID-19 Vaccination ³	Not Available	Not Available	75%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 190: Fidelis Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	
438.228: Grievance and Appeal System	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 191: Fidelis Care’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Fidelis Care failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 192: Fidelis Care Partial Capitation Network Gaps, Quarter 4 2023

Fidelis Partial Capitation Network Gaps Quarter 4 2023				
Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Adult Day Health Care		1		
Audiology Services	2	1		
Fiscal Intermediary	1	3		1
Institutional Long Term Care		2		
Institutional Long Term Care (Vent Skilled Nursing Facility)		2	1	
Institutional Short Term Care		2		
Optometry	8			
Oral Surgery	2			
Podiatry	2			
Social Day Care	7	4	2	3
Telehealth	3	1	2	3
Therapy: Occupational	1			
Therapy: Respiratory	3			
Therapy: Speech and Language	3	1		

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 193: Fidelis Care’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	92%	80%	82%
Rating of Dentist	71%	79%	72%
Rating of Care Manager	85%	78%	87%
Rating of Regular Visiting Nurse	87%	77%	84%
Rating of Home Health Aide	97%	87%	93%
Rating of Transportation Services	82%	65%	72%
Timeliness of Home Health Aide	96%	95%	95%
Timeliness Composite	79%	84%	85%
Involved in Decisions	87%	83%	84%
Manage Illness	83%	83%	85%
Access to Routine Dental Care	33%	36%	35%
Same Day Urgent Dental Care	19%	20%	26%
Plan Asked to See Medicines	85%	91%	93%
Talked About Appointing for Health Decisions	81%	80%	74%
Document Appointing for Health Decisions	69%	74%	61%
Plan Has Document Appointing for Health Decisions	85%	91%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 194: Fidelis Care’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Fidelis Care demonstrated improvement between measurement years 2022 and 2023. All four performance improvement project indicator rates exceeded Fidelis Care’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	One performance measure rate calculated by the Department of Health for Fidelis Care for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Fidelis Care met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Fidelis Care performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Fidelis Care for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Fidelis Care as not in full compliance with one standard of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Fidelis Care has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Fidelis Care performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fidelis Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Fidelis Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fidelis Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Fidelis Care pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Fidelis Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 195: Hamaspik’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Hamaspik’s Response	IPRO’S Assessment of Hamaspik’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Hamaspik should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Hamaspik continued to incorporate social determinants of health into care management training and services for their members through 2024. Staff and member resources are maintained and updated to ensure interventions can be implemented and carried out, as needed. By the end of 2023, Hamaspik consistently targeted education and collaboration with members and providers to support successful interventions of positive social determinants of health indicators.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>Hamaspik should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Hamaspik should focus on enhancing areas of care where its rates are</p>	<p>Hamaspik monitors performance rates on a weekly basis and compares rates to the most recent data from the crude reports showing statewide percentiles and averages. Interventions and improvement are targeted to measures performing lower than statewide averages.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Hamaspik's Response	IPRO'S Assessment of Hamaspik's Response
below the Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Hamaspik's compliance department includes staff who conduct internal audits focused on key elements of managed long-term care and Medicaid Advantage Plus compliance. Audits include care management contact frequency and documentation; enrollment and disenrollment documentation; utilization review and appeals timeliness and documentation; consumer-directed personal assistance services documentation; member services standards for timeliness and accuracy; and utilization of key services that determine member eligibility.	Partially addressed.

Performance Improvement Project Summaries and Results

Table 196: Hamaspik's Performance Improvement Project Summary, 2023

Hamaspik's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for new members within the first 30 days of enrollment. ▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for members who have been continuously enrolled with Hamaspik. ▪ Hamaspik aims to improve the rate of care manager contacts where a social determinants of health screen is conducted. ▪ Hamaspik aims to determine the percentage of members who have a positive social determinants of health assessment. ▪ Hamaspik aims to improve the rate of members with a positive social determinants of health assessment who have documented interventions to address the identified need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p>

Hamaspik's Performance Improvement Project Summary

- Utilized a social determinants of health assessment tool within Hamaspik's electronic medical record system enabling direct reporting of the performance improvement project's indicators.
- Trained care managers on social determinants of health.

Member-Focused 2023 Interventions

- Created and distributed an educational resource for managed long-term care members highlighting both key plan benefits that address potential social determinants of health concerns and community resources and how to access them.

Provider-Focused 2023 Intervention

- Collaborated with in-network home care services agencies and primary care providers to engage members with positive social determinants of health indicators.

Table 197: Hamaspik's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023 ¹	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	26.67%	61.29%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	1.17%	80.74%	25.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	1.03%	12.99%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	25.00%	9.62%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	96.94%	95.00%

¹ The Extended MLTC partial capitation membership joined Hamaspik's partial capitation product on August 1st, 2023.

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 198: Hamaspik Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	59%	53%	68%
No Severe Daily Pain	Not Available	99%	99%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	76%	75%	78%
Pneumococcal Vaccination	Not Available	83%	85%	80%
COVID-19 Vaccination ³	Not Available	Not Available	46%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 199: Hamaspik’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 200: Hamaspik’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Hamaspik failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 201: Hamaspik Partial Capitation Network Gaps, Quarter 4 2023

Hamaspik Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	1	3
Audiology Services	1	1
Optometry	3	
Oral Surgery	1	1
Social Day Care		1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 202: Hamaspik’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Hamaspik Measurement Year 2021	Hamaspik Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	88%	81%	82%
Rating of Dentist	79%	79%	72%
Rating of Care Manager	90%	89%	87%
Rating of Regular Visiting Nurse	86%	86%	84%
Rating of Home Health Aide	94%	95%	93%
Rating of Transportation Services	84%	82%	72%
Timeliness of Home Health Aide	93%	92%	95%
Timeliness Composite	85%	84%	85%
Involved in Decisions	88%	83%	84%
Manage Illness	86%	85%	85%
Access to Routine Dental Care	37%	33%	35%
Same Day Urgent Dental Care	22%	24%	26%
Plan Asked to See Medicines	89%	89%	93%
Talked About Appointing for Health Decisions	78%	70%	74%
Document Appointing for Health Decisions	76%	67%	61%
Plan Has Document Appointing for Health Decisions	80%	77%	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 203: Hamaspik's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Hamaspik's performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Hamaspik demonstrated improvement between measurement years 2022 and 2023. All four performance improvement project indicator rates exceeded Hamaspik's 2023 target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Hamaspik for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Hamaspik met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Hamaspik performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Hamaspik demonstrated a decline between measurement years 2022 and 2023.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Hamaspik for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Hamaspik was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Hamaspik has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Hamaspik should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Hamaspik should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Hamaspik should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Hamaspik should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Fallon Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Hamaspik pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Hamaspik should evaluate member satisfaction and address adverse member experience with	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	areas linked to quality, timeliness, and access to care.			

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 204: iCircle’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	iCircle’s Response	IPRO’S Assessment of iCircle’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, iCircle should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>iCircle has evaluated the impact of completing assessment and screening of social determinant of health needs with the iCircle membership. As a result, iCircle has determined this process should be sustained and currently continues the assessment and screening of social determinants of health needs while putting interventions in place whenever indicated. iCircle has also increased monitoring and analysis of the current and ongoing performance improvement project by conducting quarterly evaluations, with the goal of focusing on improved member care and program efficiency and to facilitate the performance improvement project team’s adjustments of interventions in real time. Established goals that have been determined as met are retired and new goals and interventions are developed. This process has helped the project become more fluid to ensure iCircle is able to focus on interventions with high impact.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>iCircle should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement</p>	<p>iCircle will integrate the Department of Health’s health assessment data findings into its quality improvement plan. Key measures will be identified and targeted interventions will be</p>	<p>Partially addressed.</p>

2022 External Quality Review Recommendation	iCircle's Response	IPRO'S Assessment of iCircle's Response
<p>program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, iCircle should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>implemented by the second quarter of 2025. An example of one planned intervention is the implementation of a member-incentive program to improve compliance with preventive health measures. The expected goal is to improve care delivery, increase access, and achieve better health outcomes. The effectiveness of targeted interventions will be tracked through performance measure reviews.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>iCircle should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>iCircle focuses on areas of non-compliance that have been identified by the Department of Health. All areas of non-compliance are reviewed and addressed in a plan of corrective action with a schedule of implementation that is agreed and approved upon review schedule. In the event of changes to a process that directly impacts a specific area of compliance, iCircle's Quality and Compliance Department works and coordinates with the Department of Health to ensure timely review of tools and that process changes are approved. Since receiving the survey results, iCircle has implemented new workflows and oversight measures to improve compliance, such as implementation of a new person-centered service plan template to better capture authorized services, improvement of the service request notification process (which now includes automation of verbal notification), and increased education regarding care coordination. iCircle's Quality and Compliance Department reviews</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	iCircle's Response	IPRO'S Assessment of iCircle's Response
	and monitors the areas of non-compliance and then guides efforts to address performance areas below the Medicaid Managed Long-term Care program averages.	

Performance Improvement Project Summaries and Results

Table 205: iCircle's Performance Improvement Project Summary, 2023

iCircle's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p>
<p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p>
<p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ iCircle aims to increase the percentage of new enrollees who undergo a stand-alone assessment for social determinants of health within 30 days of enrollment. ▪ iCircle aims to increase the percentage of continuously enrolled members who undergo at least one stand-alone assessment within the measurement year. ▪ iCircle aims to increase the percentage of quarterly routine care manager contacts where a screening was performed for social determinants of health. ▪ iCircle aims to decrease the number of members with a positive social determinants of health assessment. ▪ iCircle aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Trained clinical staff on the five domains of social determinants of health. ▪ Partnered with Find Health to refer members to an existing resource that addresses social determinants of health.

Table 206: iCircle’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	59.94%	82.78%	65.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	86.50%	94.37%	90.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	24.80%	33.26%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	36.45%	37.49%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 207: iCircle Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	45%	43%	68%
No Severe Daily Pain	Not Available	76%	78%	96%
Pain Controlled	Not Available	80%	82%	98%
Not Lonely or Not Distressed	Not Available	84%	86%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	70%	69%	78%
Pneumococcal Vaccination	Not Available	77%	76%	80%
COVID-19 Vaccination ³	Not Available	Not Available	65%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 208: iCircle's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	NC	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 209: iCircle’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
iCircle failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 210: iCircle Partial Capitation Network Gaps, Quarter 4 2023

iCircle Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	2	1
Audiology Services	3	
Dentistry		1
Licensed Home Health Care: Home Based Medical Social Services	1	
Certified Home Health: Home Based Medical Social Services	8	
Nutrition	1	
Oral Surgery	5	2
Podiatry	4	2
Social Day Care	4	3

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 211: iCircle’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	iCircle Measurement Year 2021	iCircle Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	92%	87%	82%
Rating of Dentist	67%	62%	72%
Rating of Care Manager	92%	89%	87%
Rating of Regular Visiting Nurse	82%	82%	84%
Rating of Home Health Aide	95%	91%	93%
Rating of Transportation Services	87%	76%	72%
Timeliness of Home Health Aide	92%	88%	95%
Timeliness Composite	80%	81%	85%
Involved in Decisions	90%	91%	84%
Manage Illness	83%	87%	85%
Access to Routine Dental Care	39%	27%	35%
Same Day Urgent Dental Care	23%	14%	26%
Plan Asked to See Medicines	90%	94%	93%
Talked About Appointing for Health Decisions	64%	68%	74%
Document Appointing for Health Decisions	70%	70%	61%
Plan Has Document Appointing for Health Decisions	75%	68%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 212: iCircle’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	iCircle’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by iCircle demonstrated improvement and one remained static between measurement years 2022 and 2023. All four performance improvement project indicator rates exceeded iCircle’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	iCircle met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	iCircle performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	All seven performance measure rates calculated by the Department of Health for iCircle for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, iCircle was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	iCircle has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	iCircle performed significantly worse than the Medicaid Managed Long-Term Care program on five measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, iCircle should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	replaced based on the results of a recent barrier analysis.			
Performance Measures	iCircle should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, iCircle should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	iCircle should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. iCircle should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended iCircle pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	iCircle should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 213: Kalos Health’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Kalos Health’s Response	IPRO’S Assessment of Kalos Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Kalos Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Kalos Health maintains access to the social determinants of health educational modules from the Healthy People 2030 website along with the inventory of interventions for each target risk topic, including referral to internal social worker personnel. Kalos Health has not maintained completion of a separate social determinants of health risk assessment tool. All performance improvement project activities ceased as of December 1st, 2024, due to the cessation of member-facing functions by Kalos Health.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Kalos Health should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Kalos Health should focus on enhancing areas of care where its rates are</p>	<p>Kalos Health’s Quality Department personnel compile and distribute monthly quality measure data from internal sources, and map year-over-year performance from the State’s Annual Managed Long-term Care Report. Kalos Health was approved to start a member-level health goal completion incentive program, and was pursuing measure-specific interventions for below target measures; however, all quality activity ceased as of December 1st, 2024, due to Kalos Health’s cessation of member-facing functions.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Kalos Health's Response	IPRO'S Assessment of Kalos Health's Response
below the Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Kalos Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2021-2022 compliance findings. Kalos Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Kalos Health's Quality Department personnel solicit, compile, and distribute updates monthly for each of the 2021-2022 survey deficiencies from the respective deficiency stakeholders. Urgent issues are addressed ad hoc, with a review of statuses and any additional changes to strategy or actions to be discussed at the quarterly Quality Assurance and Process Improvement Committee meetings. Kalos Health ceased member-facing functions as of December 1 st , 2024, so any compliance needs will be addressed by remaining personnel.	Addressed.

Performance Improvement Project Summaries and Results

Table 214: Kalos Health's Performance Improvement Project Summary, 2023

Kalos Health's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Kalos Health aims to increase the percentage of new and continuing members who are assessed for social determinants of health risks. ▪ Kalos Health aims to ensure that members with one or more social determinants of health risks have at least one mitigating intervention implemented for each social determinant of health risk. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Trained staff who are designated to perform social determinants of health assessments on related operational processes. ▪ Reported and discussed screening metrics, risk-mitigating interventions / resource availability and efficacy during routine Quality Assurance meetings. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Updated the care plan of members with a social determinant of health risk to reflect the identified risk and the intervention/resource applied to mitigate the risk.

Table 215: Kalos Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	0.00%	90.34%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	0.42%	66.67%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	0.37%	12.21%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	100.00%	99.24%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	99.34%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 216: Kalos Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	54%	58%	68%
No Severe Daily Pain	Not Available	97%	100%	96%
Pain Controlled	Not Available	93%	98%	98%
Not Lonely or Not Distressed	Not Available	90%	96%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	71%	72%	78%
Pneumococcal Vaccination	Not Available	84%	83%	80%
COVID-19 Vaccination ³	Not Available	Not Available	78%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 217: Kalos Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 218: Kalos Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Kalos Health failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 219: Kalos Partial Capitation Network Gaps, Quarter 4 2023

Kalos Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Care		1
Certified Home Health		1
Certified Home Health: Home Based Medical Social Services		1
Certified Home Health Home Based Occupational Therapy		1
Certified Home Health: Home Based Physical Therapy		1
Certified Home Health: Home Based Speech Therapy		1
Social Day Care	1	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 220: Kalos Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Kalos Health Measurement Year 2021	Kalos Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	79%	83%	82%
Rating of Dentist	72%	77%	72%
Rating of Care Manager	83%	86%	87%
Rating of Regular Visiting Nurse	72%	87%	84%
Rating of Home Health Aide	77%	86%	93%
Rating of Transportation Services	75%	69%	72%
Timeliness of Home Health Aide	89%	89%	95%
Timeliness Composite	78%	80%	85%
Involved in Decisions	76%	83%	84%
Manage Illness	80%	82%	85%
Access to Routine Dental Care	33%	46%	35%
Same Day Urgent Dental Care	14%	25%	26%
Plan Asked to See Medicines	92%	91%	93%
Talked About Appointing for Health Decisions	65%	68%	74%
Document Appointing for Health Decisions	84%	73%	61%
Plan Has Document Appointing for Health Decisions	87%	84%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 221: Kalos Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Kalos Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Kalos Health demonstrated improvement and one remained static between measurement years 2022 and 2023. All four performance improvement project indicator rates exceeded Kalos Health’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	One performance measure rate calculated by the Department of Health for Kalos Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Kalos Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Kalos Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Kalos Health for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Kalos Health was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Kalos Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Kalos Health performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Kalos Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Kalos Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Kalos Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Kalos Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Kalos Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Kalos Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Kalos Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 222: MetroPlus’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	MetroPlus’s Response	IPRO’S Assessment of MetroPlus’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, MetroPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>MetroPlus continues to monitor and review clinical documentation associated with social determinants of health to better support members’ individual needs. MetroPlus utilizes a stand-alone social determinants of health assessment. Care managers make monthly calls to identified members and provide focused interventions. MetroPlus continues to monitor monthly and conducts the stand-alone assessment annually, which allows for continuous quality improvement.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>MetroPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, MetroPlus should focus on enhancing areas of care where its rates are</p>	<p>MetroPlus has implemented utilization of the quality analysis software, Lenavi, to monitor and track gaps in care noted on the health assessment. The Universal Assessment System assessor utilizes the Lenavi system to perform quality checks. The Care Management team then develops individualized goals and interventions for each member. Minimally, monthly contact is made with each member to review interventions, goals, and outcomes to ensure members are receiving</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	MetroPlus's Response	IPRO'S Assessment of MetroPlus's Response
below the Medicaid Managed Long-term Care program mean.	adequate care and improved health outcomes.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
MetroPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	MetroPlus continues to maintain a compliance program with an assigned compliance specialist to ensure adherence to all applicable requirements. Through a risk assessment, MetroPlus' Compliance Committee develops an annual compliance workplan which is then executed by the compliance team. Identified risks such as utilization, grievance, appeals, and claims are included and monitored regularly. These findings are then reported to MetroPlus' governing body.	Addressed.

Performance Improvement Project Summaries and Results

Table 223: MetroPlus's Performance Improvement Project Summary, 2023

MetroPlus's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ MetroPlus aims to increase the rate for social determinants of health screening among new members. ▪ MetroPlus aims to increase the rate for social determinants of health screening among continuously enrolled members. ▪ MetroPlus aims to increase subsequent follow-up to address social determinants of health needs among members with a positive screen using clinical and non-clinical interventions. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Enabled a system generated report to support quarterly monitoring of members with social determinants of health needs. ▪ Trained care managers on the use of the social determinants of health screening tool and appropriate selection of interventions. <p><u>Member-Focused 2023 Intervention</u></p> <ul style="list-style-type: none"> ▪ Monitored members with a positive social determinants of health assessment to ensure implementation of at least one intervention.

Table 224: MetroPlus’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	44.75%	79.23%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	63.03%	93.01%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	5.28%	11.55%	50.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	32.94%	23.96%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	96.71%	96.30%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 225: MetroPlus Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	90%	92%	68%
No Severe Daily Pain	Not Available	100%	98%	96%
Pain Controlled	Not Available	98%	96%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	83%	78%	78%
Pneumococcal Vaccination	Not Available	81%	77%	80%
COVID-19 Vaccination ³	Not Available	Not Available	84%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021. ² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 226: MetroPlus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	NC	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	C
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	C	
438.214: Provider Selection	C	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	NC	
438.230: Subcontractual Relationships and Delegation	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 227: MetroPlus’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Twenty-seven records submitted for review contained Person-Centered Service Plans that did not consistently indicate the scope of services and/or a completed back-up plan.	Managed Long-Term Care Partial Capitation Contract Article V J.1 Article V J.9.c.vi-vii	438.208
Twenty-two records submitted for review lacked evidence of a 6 month care management home visit.	Managed Long-Term Care Partial Capitation Contract Article V J.6.b	438.208
Seven records submitted for review lacked evidence of monthly care management contact with the enrollee or documented attempts.	Managed Long-Term Care Partial Capitation Contract Article V J.6.a.	438.208
Two records submitted for review that contained a disenrollment did not include evidence that MetroPlus provided the proposed disenrollment date in writing to the enrollee prior to the effective date of disenrollment.	Managed Long-Term Care Partial Capitation Contract Article V D.1.e	438.56
Ten records submitted for review contained service request determination notices that were not sent within the required timeframe.	Managed Long-Term Care Partial Capitation Contract Appendix K	438.228
Forty records submitted for review did not contain an enrollment agreement or contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment, did not contain the proposed date of enrollment, and/or was not signed by the enrollee or designated representative.	Managed Long-Term Care Partial Capitation Contract Article V H.5	438.242

Network Adequacy Results

Table 228: MetroPlus Partial Capitation Network Gaps, Quarter 4 2023

MetroPlus Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Institutional Long Term Care		1
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	1
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	1
Licensed Home Health Care: Home Based Medical Social Services		4
Licensed Home Health Care: Home Based Speech Therapy		4
Private Duty Nursing	1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 229: MetroPlus’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	83%	83%	82%
Rating of Dentist	75%	73%	72%
Rating of Care Manager	86%	79%	87%
Rating of Regular Visiting Nurse	82%	68%	84%
Rating of Home Health Aide	93%	90%	93%
Rating of Transportation Services	70%	69%	72%
Timeliness of Home Health Aide	95%	92%	95%
Timeliness Composite	80%	76%	85%
Involved in Decisions	84%	82%	84%
Manage Illness	92%	79%	85%
Access to Routine Dental Care	32%	42%	35%
Same Day Urgent Dental Care	18%	15%	26%
Plan Asked to See Medicines	89%	89%	93%
Talked About Appointing for Health Decisions	72%	70%	74%
Document Appointing for Health Decisions	59%	55%	61%
Plan Has Document Appointing for Health Decisions	71%	81%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 230: MetroPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus's performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by MetroPlus demonstrated improvement and one remained static between measurement years 2022 and 2023. Three performance improvement project indicator rates exceeded MetroPlus's 2023 target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for MetroPlus for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, MetroPlus was in compliance with 10 standards of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	MetroPlus met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by MetroPlus did not meet MetroPlus's 2023 target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for MetroPlus for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, MetroPlus was not in full compliance with four standards of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	MetroPlus has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	MetroPlus performed significantly worse than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MetroPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	MetroPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, MetroPlus should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	MetroPlus should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. MetroPlus should conduct internal reviews as it prepares for the compliance review conducted.	X	X	X
Network Adequacy	It is recommended MetroPlus pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	MetroPlus should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Montefiore Partial Capitation ceased operations within measurement year 2023. Montefiore Partial Capitation Plan was acquired by RiverSpring/ElderServe MLTC Partial Capitation Plan on 12/31/2023.

Performance Improvement Project Summaries and Results

Table 231: Montefiore’s Performance Improvement Project Summary, 2023

Montefiore’s Partial Capitation Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none">Montefiore aims to increase screening and follow-up rates for social determinants of health needs to all continuously enrolled adult members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">Trained all care management staff on social determinants of health.Conducted community resource referral platform training for all care management staff.Updated program description and workflows to incorporate social determinants of health screening and interventions more frequently.

Table 232: Montefiore’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023 ¹	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	88.40%	90.43%	93.06%	95.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	85.15%	92.72%	96.42%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	14.19%	15.23%	16.07%	16.67%
Percentage of members with a positive social determinants of health assessment	3.81%	2.53%	1.86%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	100.00%	86.67%	95.24%	100.00%

¹ The final measurement year was January 1st, 2023, through November 30th, 2023, due to Montefiore’s Partial Capitation membership transfer to RiverSpring effective December 31st, 2023.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 233: Montefiore Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	67%	68%	68%
No Severe Daily Pain	Not Available	96%	97%	96%
Pain Controlled	Not Available	90%	85%	98%
Not Lonely or Not Distressed	Not Available	90%	92%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	81%	81%	78%
Pneumococcal Vaccination	Not Available	72%	73%	80%
COVID-19 Vaccination ³	Not Available	Not Available	83%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 234: Montefiore's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	C
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	C	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.228: Grievance and Appeal System	C	
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 235: Montefiore’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
The majority of person centered service plans on record did not consistently indicate the scope of services. Please note, this deficiency was identified in a prior Department survey and remains out of compliance.	Managed Long-Term Care Partial Capitation Contract Article V J.1 Article V J.9.c.vii	438.208
Thirteen records that indicated the enrollee was receiving consumer directed personal assistance services did not contain current physician orders.	Regulation Title 18 New York Codes, Rules, Regulations 505.28 (3)(e)(5) 505.28 (3)(f)(1)	438.208
Montefiore failed to provide evidence that credentialing and re-credentialing is performed on participating providers on a periodic basis (initially and not less than once every three (3) years) and for monitoring provider performance.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII C. 1	438.214
Montefiore failed to submit to the Department for approval a new Management Services Agreement at least 90 days prior to the management contract’s proposed effective date. On August 19, 2022, Montefiore Diamond Care was notified by Healthplex, Inc. of termination without cause of the dental services management agreement, effective at midnight on December 31, 2022. Montefiore failed to submit to the Department for approval the new Management Services Agreement with Liberty Dental at least 90 days prior to the management contract’s proposed effective date. The request for approval was received by the Department on November 7, 2022, for the	Part 98 of New York Codes, Rules and Regulations Section 98-1.11 (k) Section 98-1.11 (m)	438.230

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
contract that was effective January 1, 2023.		
Montefiore did not provide sufficient evidence that the Board of Directors met four (4) times in 2019, 2020, 2021, and 2022.	Managed Long-Term Care Partial Capitation Contract Article V F.1(a) Regulation Title 10 New York Codes, Rules, Regulations Section 98-1. (f) (1) (iii)	438.242
Two records submitted for review contained an incomplete enrollment agreement that did not include the projected date of enrollment.	Managed Long-Term Care Partial Capitation Contract Article V H. 5	438.242

Network Adequacy Results

Table 236: Montefiore Partial Capitation Network Gaps, Quarter 4 2023

Montefiore Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Licensed Home Health Care: Home Based Speech Therapy	2	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network .

Quality-of-Care Survey Results – Member Experience

Table 237: Montefiore’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Montefiore Measurement Year 2021	Montefiore Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	94%	89%	82%
Rating of Dentist	76%	69%	72%
Rating of Care Manager	92%	86%	87%
Rating of Regular Visiting Nurse	83%	74%	84%
Rating of Home Health Aide	96%	90%	93%
Rating of Transportation Services	80%	63%	72%
Timeliness of Home Health Aide	98%	92%	95%
Timeliness Composite	85%	83%	85%
Involved in Decisions	84%	84%	84%
Manage Illness	91%	81%	85%
Access to Routine Dental Care	37%	38%	35%
Same Day Urgent Dental Care	19%	33%	26%
Plan Asked to See Medicines	97%	90%	93%
Talked About Appointing for Health Decisions	80%	75%	74%
Document Appointing for Health Decisions	70%	71%	61%

Measure	Montefiore Measurement Year 2021	Montefiore Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Plan Has Document Appointing for Health Decisions	91%	89%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 238: Montefiore’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Montefiore’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Please note that the final measurement year was January 1 st , 2023, through November 30 th , 2023, due to Montefiore’s Partial Capitation membership transfer to RiverSpring effective December 31 st , 2023. Three of four performance improvement project indicator rates reported by Montefiore demonstrated improvement and one remained static between measurement years 2022 and 2023.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Montefiore for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, Montefiore was in compliance with ten standards of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	Montefiore met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Montefiore performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	The final measurement year was January 1 st , 2023, through November 30 th , 2023, due the Partial Capitation membership transfer to RiverSpring effective December 31 st , 2023. None of the four performance improvement project indicator rates met their 2023 targeted rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Montefiore for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, Montefiore was not in full compliance with four standards of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Montefiore has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Montefiore performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project, Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy, Quality-of-Care Survey	Montefiore was acquired by RiverSpring/ElderServe MLTC Partial Capitation Plan on 12/31/2023; Montefiore is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendations were made.			

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 239: Nascentia’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Nascentia’s Response	IPRO’S Assessment of Nascentia’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Nascentia should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Nascentia receives daily alerts of hospitalizations and emergency room visits for members, ensuring timely follow-up by care managers. Members with two or more hospitalizations are reviewed monthly in complex case conferences to prevent readmissions. Clinical support nurses and disease management pathways provide additional education, while transitions of care scripts ensure appropriate follow-up all in attempts to prevent hospitalizations. Monthly reports are used to determine the effectiveness of the interventions.</p>	<p>Remains an Opportunity for Improvement.</p>
Validation of Performance Measures		
<p>Nascentia should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Nascentia should focus on enhancing areas of care where its rates are</p>	<p>Nascentia uses Audicus for home hearing evaluations, which are reviewed by a licensed audiologist. Monthly scorecard meetings are held to assess gaps in care and to develop targeted interventions. These interventions are tracked by the Lenavi software program which scrubs Universal Assessment System assessments. This data then feeds into a weekly quality incentive report, reviewed by Nascentia’s leadership team. Any actionable items are addressed with care management teams, and trends are discussed for further education.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Nascentia's Response	IPRO'S Assessment of Nascentia's Response
below the Medicaid Managed Long-term Care program mean.	Data is then reported on a quarterly basis with discussion on ways to improve.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Nascentia should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Nascentia should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Monthly comprehensive chart audits are focused on Department of Health findings and the results are then reported quarterly. Supervisors review the results of the audits on a monthly basis with care managers. Consumer-directed personal assistance, physician's orders, and monthly contacts are tracked in daily reports. The patient-centered specialty practice was updated to ensure person-centered services and backup plans are in place. Education on Department of Health compliance, including action notices, is completed in orientation and annually for staff. Triennial audits are done for all fiscal intermediaries and annually for social day programs.	Addressed.

Performance Improvement Project Summaries and Results

Table 240: Nascentia’s Performance Improvement Project Summary, 2023

Nascentia’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none"> Nascentia aims to increase screening and follow-up rates for social determinants of health needs among all managed long-term care members by using clinical and non-clinical interventions. <p><u>Managed Care Plan-Focused 2023 Intervention</u></p> <ul style="list-style-type: none"> Provided training and education to care managers regarding the prevalence, impact, and mitigation of social determinants of health among the managed long-term care population. <p><u>Member-Focused 2023 Intervention</u></p> <ul style="list-style-type: none"> Documented social determinants of health findings that required intervention(s) within the member’s care plan along with a resolution.

Table 241: Nascentia’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	41.64%	63.77%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	26.05%	86.15%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	58.48%	86.79%	75.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	72.02%	48.92%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	32.91%	31.51%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 242: Nascentia Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	54%	50%	68%
No Severe Daily Pain	Not Available	94%	95%	96%
Pain Controlled	Not Available	93%	93%	98%
Not Lonely or Not Distressed	Not Available	97%	97%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	70%	71%	78%
Pneumococcal Vaccination	Not Available	75%	76%	80%
COVID-19 Vaccination ³	Not Available	Not Available	76%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 243: Nascentia's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	C	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	C	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 244: Nascentia’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Nascentia failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII.A.1 Article VII.D.2 Article VII.D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 245: Nascentia Partial Capitation Network Gaps, Quarter 4 2023

Nascentia Partial Capitation Network Gaps Quarter 4 2023				
Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Adult Day Health Care	6	8		
Audiology Services	10			
Certified Home Health		6		
Certified Home Health: Home Based Medical Social Services	1	6		
Certified Home Health: Home Based Occupational Therapy		6		
Certified Home Health: Home Based Physical Therapy		6		
Certified Home Health: Home Based Speech Therapy		6		
Fiscal Intermediary	9	4	2	2
General Dentistry		1		
Institutional Long Term Care		4		
Institutional Long Term Care (Vent Skilled Nursing Facility)	4	2		
Institutional Short Term Care	1	3		
Licensed Home Health Care: Home Based Medical Social Services	9	14		

Nascentia Partial Capitation Network Gaps Quarter 4 2023

Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Licensed Home Health Care: Home Based Occupational Therapy	9	12		
Licensed Home Health Care: Home Based Physical Therapy	6	10		
Licensed Home Health Care: Home Based Speech Therapy	12	20		
Optometry	2	4		
Oral Surgery	2	1		
Podiatry	6	10		
Social Day Care	4	6		2
Telehealth	9	1	3	7
Therapy: Occupational	6	1		
Therapy: Physical	2			
Therapy: Speech and Language	7	1		

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 246: Nascentia’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Nascentia Measurement Year 2021	Nascentia Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	91%	82%	82%
Rating of Dentist	77%	71%	72%
Rating of Care Manager	86%	91%	87%
Rating of Regular Visiting Nurse	79%	87%	84%
Rating of Home Health Aide	95%	92%	93%
Rating of Transportation Services	80%	80%	72%
Timeliness of Home Health Aide	98%	94%	95%
Timeliness Composite	80%	85%	85%
Involved in Decisions	87%	92%	84%
Manage Illness	91%	89%	85%
Access to Routine Dental Care	46%	38%	35%
Same Day Urgent Dental Care	38%	9%	26%
Plan Asked to See Medicines	93%	91%	93%
Talked About Appointing for Health Decisions	67%	74%	74%
Document Appointing for Health Decisions	76%	73%	61%
Plan Has Document Appointing for Health Decisions	73%	81%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 247: Nascentia’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Nascentia’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Nascentia demonstrated improvement between measurement years 2022 and 2023. Three of four performance improvement indicator rates exceeded their 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Nascentia met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Nascentia performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement indicator rates reported by Nascentia demonstrated a decline between measurement years 2022 and 2023 and did not meet the 2023 target rate.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Nascentia for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2023 review, Nascentia was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Nascentia has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Nascentia performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Nascentia should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Nascentia should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Nascentia should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	Nascentia should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Nascentia should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Nascentia pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Nascentia should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Prime Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Prime Health Partial Capitation ceased operations before the production of the 2023 External Quality Review Annual Technical Report. Due to Prime Health Partial Capitation's departure from the Managed Long-Term Care program, a response could not be obtained.

Performance Improvement Project Summaries and Results

Table 248: Prime Health's Performance Improvement Project Summary, 2023

Prime Health's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aim</u></p> <ul style="list-style-type: none">Prime Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment.Prime Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment who received education on health management strategies.Prime Health aims to increase the percentage of members with a positive social determinants of health assessment who have a documented intervention to address their need(s).
<p><u>Managed Care Plan-Focused 2023 Intervention</u></p> <ul style="list-style-type: none">Educated staff on the prevalence and health impacts of social determinants of health.
<p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">Screened members for social determinants of health needs and made resource referrals when appropriate.

Table 249: Prime Health's Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	87.69%	40.43%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	92.73%	78.08%	30.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	90.00%	16.13%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	64.81%	43.56%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	94.05%	90.90%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 250: Prime Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	66%	66%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	100%	99%	98%
Not Lonely or Not Distressed	Not Available	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	84%	79%	78%
Pneumococcal Vaccination	Not Available	83%	81%	80%
COVID-19 Vaccination ³	Not Available	Not Available	87%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 251: Prime Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	NC	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	C	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 252: Prime Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
2023 Comprehensive Survey		
Prime Health failed to provide evidence that monitoring of providers is performed for Fiscal Intermediaries.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII C.1	438.206
Prime Health failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206
The majority of person centered service plans on record did not consistently indicate the scope, duration, and/or frequency of services.	Managed Long-Term Care Partial Capitation Contract Article V J.1 Article V J.9.c.vii	438.208
Records submitted for review did not include evidence that enrollees were provided with written notification of the person centered service plan.	Managed Long-Term Care Partial Capitation Contract Article V J.9.c.ii. Article V J.6.d.iv	438.208
Seven records that indicated the enrollee was receiving consumer directed personal assistance services did not contain current physician orders.	Regulation Title 18 New York Codes, Rules, Regulations 505.28 (3)(e)(5) 505.28 (3)(f)(1)	438.208
One initial adverse determination notice sent as the result of a reduction did not show evidence that the notice was	Managed Long-Term Care Partial Capitation Contract	438.210

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
sent ten days prior to the effective date of the intended action.	Appendix K Managed Long-Term Care Policy 16.06	
Prime Health failed to provide evidence of appropriate credentialing to confirm qualifications and complete background checks for all personnel.	Managed Long-Term Care Partial Capitation Contract Article V J. 2, 5(g)	438.214
Prime Health failed to provide evidence that credentialing and re-credentialing is performed on participating providers on a periodic basis.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII C.1 Article VIII F.3 (p) (iv)	438.214
For one record, Prime Health failed to follow the required appeal process; Prime Health inaccurately issued a new service request determination instead of processing as an appeal of member's reduction, thus denying aid to continue benefit.	Managed Long-Term Care Partial Capitation Contract Appendix K	438.228
Prime Health failed to submit to the Department for approval a new Management Services Agreement at least 90 days prior to the management contract's proposed effective date.	Part 98 of New York Codes, Rules and Regulations Section 98-1.11 (k) Section 98-1.11 (m)	438.230
2023 Provider Network Delivery System Focused Survey		
Prime Health failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 253: Prime Health Partial Capitation Network Gaps, Quarter 4 2023

Prime Health Partial Capitation Network Gaps Quarter 4 2023			
Provider Type With A Gap ¹	Gap Type		
	County Access	County Choice	Surrounding Area Access
Adult Day Care		4	
Audiology Services	4	2	1
Certified Home Health	3	2	
Certified Home Health: Home Based Medical Social Services	2	3	
Certified Home Health: Home Based Occupational Therapy	3	2	
Certified Home Health: Home Based Physical Therapy	4	2	

Prime Health Partial Capitation Network Gaps Quarter 4 2023

Provider Type With A Gap ¹	Gap Type		
	County Access	County Choice	Surrounding Area Access
Certified Home Health: Home Based Speech Therapy	5	1	
Certified or Licensed Home Health Care - Personal Care Assistant		3	
Durable Medical Equipment	3	1	
Fiscal Intermediary	6		1
Home Delivered and Congregate Meals	3	2	
Institutional Long Term Care		2	
Institutional Long Term Care (Vent Skilled Nursing Facility)	2		
Institutional Short Term Care	7		
Licensed Home Health Care		3	
Licensed Home Health Care: Home Based Medical Social Services	6		
Licensed Home Health Care: Home Based Occupational Therapy	7		
Licensed Home Health Care: Home Based Physical Therapy	6		
Licensed Home Health Care: Home Based Speech Therapy	7		
Non-Emergent Transportation		2	
Nutrition	5	1	
Optometry	4		
Oral Surgery	1		
Personal Emergency Response	6	1	
Podiatry	1	4	
Private Duty Nursing		4	
Social and Environmental Support	4	3	
Social Day Care	2	2	
Telehealth	5		1
Therapy: Occupational		1	
Therapy: Respiratory	5		
Therapy: Speech and Language		1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 254: Prime Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Prime Health Measurement Year 2021	Prime Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	84%	83%	82%
Rating of Dentist	77%	79%	72%
Rating of Care Manager	78%	85%	87%
Rating of Regular Visiting Nurse	70%	82%	84%

Measure	Prime Health Measurement Year 2021	Prime Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Home Health Aide	90%	94%	93%
Rating of Transportation Services	81%	72%	72%
Timeliness of Home Health Aide	94%	91%	95%
Timeliness Composite	78%	82%	85%
Involved in Decisions	87%	84%	84%
Manage Illness	77%	82%	85%
Access to Routine Dental Care	36%	38%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	20%	26%
Plan Asked to See Medicines	94%	87%	93%
Talked About Appointing for Health Decisions	59%	67%	74%
Document Appointing for Health Decisions	59%	62%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	85%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 255: Prime Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Prime Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by Prime Health exceeded their 2023 target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Prime Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, Prime Health was in compliance with eight standards of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Prime Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	All four performance improvement indicator rates reported by Prime Health demonstrated a decline between measurement years 2022 and 2023 and one did not meet Prime Health's 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, Prime Health was not in full compliance with six standards of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Prime Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Prime Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Prime Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	faced limited access to care, or experienced unfavorable health outcomes. To address this, Prime Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Prime Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Prime Health should conduct internal reviews as it prepares for the compliance review conducted.	X	X	X
Network Adequacy	It is recommended Prime Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Prime Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 256: RiverSpring’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	RiverSpring’s Response	IPRO’S Assessment of RiverSpring’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, RiverSpring should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Performance improvement plans are monitored continuously throughout the project by means of reporting, case review, and auditing. When interventions are validated, as evidenced by progress towards meeting goals, those interventions continue. Negative outcomes are reviewed in depth to determine why the intervention was not effective and to identify new interventions that may better serve the goal and member.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>RiverSpring should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, RiverSpring should focus on enhancing areas of care where its rates are</p>	<p>Community health assessment data and member satisfaction surveys are reviewed for areas of opportunity to improve member outcomes. For example, it was noted that RiverSpring members are below the statewide average in having pain and shortness of breath controlled. In response to this, a pain assessment was added to the care manager assessment with linkage to the care plan so that the member’s pain is addressed with interventions developed to reduce or alleviate the member’s pain.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	RiverSpring's Response	IPRO'S Assessment of RiverSpring's Response
below the Medicaid Managed Long-term Care program mean.	Shortness of breath is addressed via appropriate services and supports.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
RiverSpring should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. RiverSpring should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	RiverSpring conducts monthly auditing and monitoring of operations as part of the quality and compliance program. At a minimum, results are reported quarterly to stakeholders, with significant deviations reported to stakeholders immediately so corrective actions may be initiated. Auditing focuses on regulatory compliance and quality of care delivery to RiverSpring's membership with a goal of providing optimal support and services to improve member health and well-being.	Addressed.

Performance Improvement Project Summaries and Results

Table 257: RiverSpring’s Performance Improvement Project Summary, 2023

RiverSpring’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessment within the first 30 days of enrollment for all new managed long-term care members. ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessments for all continuously enrolled managed long-term care members. ▪ RiverSpring aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted for all newly and continuously enrolled managed long-term care members. ▪ RiverSpring aims to decrease the percentage of positive social determinants of health assessments for all newly and continuously enrolled managed long-term care members. ▪ RiverSpring aims to increase the percentage of documented interventions to address needs for all managed long-term care members with a positive social determinants of health assessment. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Trained staff on the social determinants of health screening tool, the prevalence and health impacts of social determinants of health, and community resources, which will be repeated annually for all staff and at orientation for new hires. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Added a recurring section to the member newsletter on social determinants of health to provide ongoing education and resources to members. ▪ Added social determinants of health education to be discussed on monthly care management calls to members.

Table 258: RiverSpring’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	22.42%	73.03%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	24.49%	88.13%	40.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	1.79%	18.45%	8.00%

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of members with a positive social determinants of health assessment	No Data To Report	3.15%	4.02%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	54.03%	63.25%	60.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 259: RiverSpring Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	41%	43%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	91%	90%	98%
Not Lonely or Not Distressed	Not Available	98%	98%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	64%	65%	78%
Pneumococcal Vaccination	Not Available	59%	60%	80%
COVID-19 Vaccination ³	Not Available	Not Available	70%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 260: RiverSpring’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	C	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 261: RiverSpring’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
RiverSpring failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 262: Riverspring Partial Capitation Network Gaps, Quarter 4 2023

Riverspring Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Certified Home Health: Home Based Medical Social Services		1
Fiscal Intermediary	2	
Home Delivered and Congregate Meals		2
Telehealth	1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 263: RiverSpring’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	RiverSpring Measurement Year 2021	RiverSpring Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	94%	86%	82%
Rating of Dentist	78%	73%	72%
Rating of Care Manager	98%	98%	87%
Rating of Regular Visiting Nurse	95%	95%	84%
Rating of Home Health Aide	98%	99%	93%
Rating of Transportation Services	82%	83%	72%
Timeliness of Home Health Aide	100%	99%	95%
Timeliness Composite	95%	94%	85%
Involved in Decisions	84%	77%	84%
Manage Illness	83%	95%	85%
Access to Routine Dental Care	54%	34%	35%
Same Day Urgent Dental Care	39%	30%	26%
Plan Asked to See Medicines	97%	92%	93%
Talked About Appointing for Health Decisions	70%	71%	74%
Document Appointing for Health Decisions	43%	49%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	87%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 264: RiverSpring’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	RiverSpring’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by RiverSpring demonstrated improvement between measurement years 2022 and 2023. All four performance improvement project rates exceeded RiverSpring’s 2023 target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for RiverSpring for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	RiverSpring met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	RiverSpring performed significantly better than the Medicaid Managed Long-Term Care program on seven measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Six performance measure rates calculated by the Department of Health for RiverSpring for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, RiverSpring was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	RiverSpring has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	RiverSpring performed significantly worse than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, RiverSpring should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	RiverSpring should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, RiverSpring should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	RiverSpring should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. RiverSpring should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended RiverSpring pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	RiverSpring should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Senior Health Partners

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 265: Senior Health Partners’ Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Senior Health Partners’ Response	IPRO’S Assessment of Senior Health Partners’ Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Senior Health Partners should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Care managers continue to complete social determinants of health assessments and implement appropriate interventions. Technological enhancements are utilized to identify and manage members missing a social determinants of health screening, including an automated report, an alert within Senior Health Partner's case management system, and a Power Business Intelligence tool that analyzes social determinants of health data. Senior staff uses the reports to ensure that members are screened annually and to monitor care plans missing social determinants of health interventions.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>Senior Health Partners should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Health Partners should</p>	<p>Senior Health Partners develops programs and partnerships to promote preventive care, address social determinants of health needs, and manage chronic issues. Care managers reach out to members monthly to address gaps in care, answer questions, coordinate care, and identify new risks. Teams that close the most gaps in care each month are recognized in team meetings. To ensure health outcome improvements, teams routinely meet to monitor measure- and</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Senior Health Partners' Response	IPRO'S Assessment of Senior Health Partners' Response
focus on enhancing areas of care where their rates are below the Medicaid Managed Long-term Care program mean.	member-level performance and adjust strategies as needed.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Senior Health Partners should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	As part of Senior Health Partners ongoing preparation activities for the Department of Health compliance review, all relevant business units review prior results to confirm compliance with federal and state Medicaid standards. In addition, the Compliance and Regulatory teams work collaboratively to monitor and review continuing compliance.	Addressed.

Performance Improvement Project Summaries and Results

Table 266: Senior Health Partners Performance Improvement Project Summary, 2023

Senior Health Partners' Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Senior Health Partners aims to improve the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Health Partners aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Health Partners aims to improve the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Senior Health Partners aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Facilitated training and developed a job aide to educate case management staff on the new tools for social determinants of health screening/care planning, as well as the social determinants of health workflow. ▪ Reviewed and updated social determinants of health screening toolkits, member educational materials, and a compilation of online / community resources posted on plan website semi-annually. <p><u>Member-Focused 2023 Intervention</u></p>

Senior Health Partners' Performance Improvement Project Summary

- Provided educational information on the importance of addressing social determinants of health barriers in achieving positive health outcomes and a compilation of online and community resources on our member website.
- Conducted follow-up outreach to members within 30 days of the implementation of an intervention addressing a social determinant of health barrier.

Table 267: Senior Health Partners' Performance Improvement Project Indicator Summary, Measurement Years 2021 – 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	45.77%	73.21%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	91.79%	85.43%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	13.54%	8.27%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	11.40%	9.14%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	46.49%	98.55%	75.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 268: Senior Health Partners' Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	88%	86%	68%
No Severe Daily Pain	Not Available	99%	98%	96%
Pain Controlled	Not Available	97%	98%	98%
Not Lonely or Not Distressed	Not Available	97%	98%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	70%	71%	78%
Pneumococcal Vaccination	Not Available	66%	68%	80%
COVID-19 Vaccination ³	Not Available	Not Available	73%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 269: Senior Health Partners' Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 270: Senior Health Partners’ Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Senior Health Partners’ failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 271: Senior Health Partners’ Partial Capitation Network Gaps, Quarter 4 2023

Senior Health Partners’ Partial Capitation Network Gaps Quarter 4 2023	
Provider Type With A Gap ¹	Gap Type
	County Access
Adult Day Health Care	2
Therapy: Speech and Language	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 272: Senior Health Partners’ Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Senior Health Partners Measurement Year 2021	Senior Health Partners Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	93%	84%	82%
Rating of Dentist	81%	69%	72%
Rating of Care Manager	86%	81%	87%
Rating of Regular Visiting Nurse	83%	80%	84%
Rating of Home Health Aide	98%	92%	93%
Rating of Transportation Services	72%	60%	72%
Timeliness of Home Health Aide	100%	97%	95%
Timeliness Composite	81%	83%	85%
Involved in Decisions	83%	83%	84%
Manage Illness	86%	86%	85%
Access to Routine Dental Care	33%	25%	35%
Same Day Urgent Dental Care	32%	23%	26%
Plan Asked to See Medicines	95%	93%	93%
Talked About Appointing for Health Decisions	84%	77%	74%
Document Appointing for Health Decisions	81%	60%	61%
Plan Has Document Appointing for Health Decisions	82%	76%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 273: Senior Health Partners' Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Health Partners' performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Senior Health Partners' demonstrated improvement between measurement years 2022 and 2023. Three of four performance improvement project indicator rates exceeded Senior Health Partners' 2023 target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Senior Health Partners for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Senior Health Partners met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates reported by Senior Health Partner's demonstrated a decline between measurement years 2022 and 2023 and one did not meet Senior Health Partner'2023 target rate.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Senior Health Partners for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2023 review, Senior Health Partners was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Senior Health Partners has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Senior Health Partners performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Health Partners should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Senior Health Partners should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Health Partners should focus on enhancing areas of care where their rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Senior Health Partners should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	prepares for the compliance review conducted by the Department of Health.			
Network Adequacy	It is recommended Senior Health Partners pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Senior Health Partners should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Senior Network Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Senior Network Health ceased operations before the production of the 2023 External Quality Review Annual Technical Report. Due to Senior Network Health’s departure from the Managed Long-Term Care program, a response could not be obtained.

Performance Improvement Project Summaries and Results

Table 274: Senior Network Health's Performance Improvement Project Summary, 2023

Senior Network Health's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">Senior Network Health aims to increase the percentage of social determinants of health assessments occurring within the first 30 days of enrollment for new members.Senior Network Health aims to increase the number of annual social determinants of health assessments for continuously enrolled members.Senior Network Health aims to increase the number of care manager contacts where a social determinants of health assessment is completed.Senior Network Health aims to improve identification of social determinants of health disparities for members.Senior Network Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s).
<p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">Educated members about social determinants of health, potential impacts of unaddressed disparities, and goals to link members with helpful resources.Referred members to services and supports as needed.Conducted monthly follow-up with members who were not able to immediately access referred services to encourage initiation of these services and contacting Community Benefits staff for assistance with changing needs.

Table 275: Senior Network Health's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	81.82%	94.00%	90.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	48.32%	89.58%	85.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	5.41%	9.72%	7.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	32.95%	83.39%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	8.62%	100.00%	85.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 276: Senior Network Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	35%	39%	68%
No Severe Daily Pain	Not Available	87%	89%	96%
Pain Controlled	Not Available	88%	90%	98%
Not Lonely or Not Distressed	Not Available	94%	93%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	76%	77%	78%
Pneumococcal Vaccination	Not Available	71%	71%	80%
COVID-19 Vaccination ³	Not Available	Not Available	73%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 277: Senior Network Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.228: Grievance and Appeal System	C	
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	C	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 278: Senior Network Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Senior Network Health failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 279: Senior Network Health Partial Capitation Network Gaps, Quarter 4 2023

Senior Network Health Partial Capitation Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Oral Surgery		1
Social Day Care	1	
Telehealth		1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 280: Senior Network Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Senior Network Health Measurement Year 2021	Senior Network Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	88%	88%	82%
Rating of Dentist	77%	72%	72%
Rating of Care Manager	89%	97%	87%
Rating of Regular Visiting Nurse	95%	93%	84%
Rating of Home Health Aide	100%	89%	93%
Rating of Transportation Services	83%	80%	72%
Timeliness of Home Health Aide	98%	94%	95%
Timeliness Composite	92%	95%	85%
Involved in Decisions	88%	87%	84%
Manage Illness	90%	86%	85%
Access to Routine Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	26%
Plan Asked to See Medicines	93%	95%	93%
Talked About Appointing for Health Decisions	67%	75%	74%
Document Appointing for Health Decisions	77%	81%	61%
Plan Has Document Appointing for Health Decisions	87%	Sample Size Too Small To Report	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 281: Senior Network Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Network Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Senior Network Health demonstrated improvement between measurement years 2022 and 2023. All four performance improvement project indicator rates	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	exceeded Senior Network Health's 2023 target rates.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Senior Network Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Senior Network Health performed significantly better than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Five performance measure rates calculated by the Department of Health for Senior Network Health for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Senior Network Health was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Senior Network Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Network Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Senior Network Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Network Health should focus on enhancing areas of care where their rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Senior Network Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Senior Network Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Senior Network Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Senior Network Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Senior Whole Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 282: Senior Whole Health’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Senior Whole Health’s Response	IPRO’S Assessment of Senior Whole Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Senior Whole Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Senior Whole Health continues to assess both newly enrolled and established members monthly via the social determinants of health assessment tool. As part of the current standard operating procedure, members with positive assessments are referred to community-based organizations to address immediate outstanding social needs.</p> <p>The interventions are evaluated monthly and found to be effective. Ineffective interventions are modified or replaced with more effective measures based on current workflows, evaluations and feedback.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Senior Whole Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.</p>	<p>Senior Whole Health continues to analyze and interpret health assessment data to shape the quality assurance and performance improvement project, including uniform assessment system review, identifying tracks and trends in quality indicators for gaps in care analysis, health disparities, and determining members at risk.</p> <p>Senior Whole Health’s goal is to implement appropriate interventions to close gaps in care,</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Senior Whole Health's Response	IPRO'S Assessment of Senior Whole Health's Response
	while providing effective management of chronic disease.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Senior Whole Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. Senior Whole Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Senior Whole Health conducts various types of internal reviews ensuring compliance. Self-monitoring, auditing, and mandatory trainings are conducted at regular intervals and annually. The Compliance Department conducts continuous risk assessments which is used to develop the internal audit work plan. Quarterly audits are performed, corrective action plans are issued for non-compliance, and continual feedback is provided to reinforce overall compliance at every level.	Addressed.

Performance Improvement Project Summaries and Results

Table 283: Senior Whole Health's Performance Improvement Project Summary, 2023

Senior Whole Health's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Senior Whole Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Whole Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ Senior Whole Health aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p>

Senior Whole Health's Performance Improvement Project Summary

- Developed a reporting mechanism to identify members with social determinants of health needs based on a completed National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience tool.
- Implemented a comprehensive member referral process to support coordination of member linkages to services and supports.
- Trained all care management and quality staff on social determinants of health and standardized assessment tool and workflow process.

Member-Focused 2023 Interventions

- Distributed an educational postcard/brochure which included the referral process and community resource guide of member identified with social determinants of health needs to community services and resources.

Table 284: Senior Whole Health's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023 ¹	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	5.48%	89.67%	75.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	21.13%	94.24%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	18.39%	25.41%	48.80%
Percentage of members with a positive social determinants of health assessment	No Data To Report	2.20%	4.54%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	20.38%	29.68%	24.50%

¹ The newly acquired AgeWell membership was included in the final measurement year.

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 285: Senior Whole Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	86%	76%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	84%	83%	78%
Pneumococcal Vaccination	Not Available	85%	87%	80%
COVID-19 Vaccination ³	Not Available	Not Available	89%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 286: Senior Whole Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	NC	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020 Comprehensive	2023 Focused ¹
438.228: Grievance and Appeal System	NC	
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 287: Senior Whole Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Senior Whole Health failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

No gaps in network adequacy were identified for Senior Whole Health in Quarter 4 of 2023.

Quality-of-Care Survey Results – Member Experience

Table 288: Senior Whole Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Senior Whole Health Measurement Year 2021	Senior Whole Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	91%	74%	82%
Rating of Dentist	62%	76%	72%
Rating of Care Manager	86%	87%	87%
Rating of Regular Visiting Nurse	81%	86%	84%
Rating of Home Health Aide	96%	94%	93%
Rating of Transportation Services	73%	73%	72%
Timeliness of Home Health Aide	95%	100%	95%
Timeliness Composite	80%	90%	85%
Involved in Decisions	77%	77%	84%
Manage Illness	80%	84%	85%
Access to Routine Dental Care	27%	38%	35%

Measure	Senior Whole Health Measurement Year 2021	Senior Whole Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Same Day Urgent Dental Care	21%	31%	26%
Plan Asked to See Medicines	92%	86%	93%
Talked About Appointing for Health Decisions	78%	63%	74%
Document Appointing for Health Decisions	80%	56%	61%
Plan Has Document Appointing for Health Decisions	88%	83%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 289: Senior Whole Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Whole Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Senior Whole Health demonstrated improvement between measurement years 2022 and 2023. Three of four performance improvement project indicator rates exceeded Senior Whole Health’s 2023 target rates. Please note that the newly acquired AgeWell membership was included in the final 2023 measurement year.	X	X	X
Performance Measures	All seven performance measure rates calculated by the Department of Health for Senior Whole Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Senior Whole Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Senior Whole Health performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One performance improvement project indicator rate did not meet Senior Whole Health's 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 review, Senior Whole Health was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	None.			
Quality-of-Care Survey	Senior Whole Health performed significantly worse than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Whole Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Senior Whole Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Whole Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Senior Whole Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Senior Whole Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended Senior Whole Health continue to pursue provider contracts to expand their provider network.		X	X
Quality-of-Care Survey	Senior Whole Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 290: VillageCare’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	VillageCare’s Response	IPRO’S Assessment of VNS Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VillageCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>VillageCare continues to monitor the Social Determinants of Health performance improvement project. VillageCare is working to develop a Health Equity Subcommittee of the Quality Management Improvement Committee. The Health Equity Subcommittee will use data from the Social Determinants of Health assessments, as well as other sources of data to identify health disparities. The subcommittee will increase awareness of the significance of health disparities and work to drive improvement toward health equity for our members.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>VillageCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.</p>	<p>VillageCare has leveraged the findings from the Department of Health's analysis to inform our internal Quality Assurance and Performance Improvement Program. We have set new initiatives to target risk areas for improvement. Initiatives include Home Care Agency and Care Manager report cards that highlight both strength and risk areas with respect to the Quality Incentives Measure Program and Member Satisfaction. Corrective action will be implemented when necessary to mitigate risk.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	VillageCare's Response	IPRO'S Assessment of VNS Health's Response
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
<p>VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>VillageCare's Quality Management Department continues to utilize its Quality Management Program and Workplan which outlines the required standards and metrics for the Managed Long-Term Care program. In addition, the Quality Management program and workplan identify the stakeholders responsible for ensuring compliance with the standards. The metrics are reported to the Quality Management Improvement Committee quarterly. When goals are not met, a corrective action plan is required, and the Quality Management Department follows the corrective action plan through to resolution.</p>	<p>Addressed.</p>

Performance Improvement Project Summaries and Results

Table 291: VillageCare’s Performance Improvement Project Summary, 2023

VillageCare’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">▪ VillageCare aims to increase stand-alone completed social determinants of health assessments for all members, both newly enrolled and continuously enrolled.▪ VillageCare aims to increase the percentage of care manager contacts where a social determinants of health assessments is conducted and decrease the number of positive social determinants of health assessments.▪ VillageCare aims to increase the number of members with positive social determinants of health assessments who have documented intervention(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Developed educational tools for care managers related to social determinants of health.▪ Trained care managers on the social determinants of health assessments and community-based organization information. <p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Conducted follow-up outreach to members with a positive social determinant of health within 90 days of a referral.

Table 292: VillageCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	89.04%	87.25%	≥90.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	21.85%	76.97%	≥90.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	13.00%	8.04%	≥50.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	40.98%	14.60%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	26.81%	65.00%	≥90.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 293: VillageCare Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	85%	83%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	78%	79%	78%
Pneumococcal Vaccination	Not Available	78%	80%	80%
COVID-19 Vaccination ³	Not Available	Not Available	84%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 294: VillageCare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	C	C
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	C	
438.214: Provider Selection	C	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	NC	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	C	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	C	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 295: VillageCare’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Thirteen records submitted for review lacked evidence of a six-month care management home visit.	Managed Long-Term Care Partial Capitation Contract Article V J.6.b	438.208
Two records submitted for review lacked evidence of monthly care management contact with the enrollee or documented attempts. Please note, this deficiency was identified in a prior Department survey and remains out of compliance.	Managed Long-Term Care Partial Capitation Contract Article V J.6.a	438.208
Four records submitted for review where the enrollee was receiving consumer directed personal assistance services did not show evidence that there were completed consumer directed personal assistance services orders that covered the full review period.	Regulation Title 18 New York Codes, Rules, Regulations 505.28 (3)(e)(5) 505.28 (3)(f)(1)	438.208
Eleven records submitted for review contained extension notices that did not include what specific information was needed to help make the determination.	Managed Long-Term Care Partial Capitation Contract Appendix K	438.228
Thirteen records submitted for review contained Service Request Determinations that were not sent, or determination notices were not sent within the required timeframe.	Managed Long-Term Care Partial Capitation Contract Appendix K	438.228

Network Adequacy Results

No gaps in network adequacy were identified for VillageCare in Quarter 4 of 2023.

Quality-of-Care Survey Results – Member Experience

Table 296: VillageCare’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	VillageCare Measurement Year 2021	VillageCare Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	90%	76%	82%
Rating of Dentist	69%	74%	72%
Rating of Care Manager	87%	87%	87%
Rating of Regular Visiting Nurse	89%	85%	84%
Rating of Home Health Aide	91%	94%	93%
Rating of Transportation Services	79%	79%	72%
Timeliness of Home Health Aide	96%	96%	95%
Timeliness Composite	85%	86%	85%
Involved in Decisions	85%	84%	84%
Manage Illness	87%	80%	85%
Access to Routine Dental Care	52%	47%	35%
Same Day Urgent Dental Care	38%	26%	26%
Plan Asked to See Medicines	93%	91%	93%
Talked About Appointing for Health Decisions	83%	65%	74%
Document Appointing for Health Decisions	49%	52%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	81%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 297: VillageCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VillageCare’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by VillageCare demonstrated improvement between measurement years 2022 and 2023.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for VillageCare for	X		X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.			
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, VillageCare was in compliance with 12 standards of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	VillageCare met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	VillageCare performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates reported by VillageCare demonstrated a decline between measurement years 2022 and 2023. All four performance improvement indicator rates did not meet VillageCare's 2023 target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 comprehensive review, VillageCare was not in full compliance with two standards of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	None.		X	X
Quality-of-Care Survey	VillageCare performed significantly worse than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VillageCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	VillageCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, VillageCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	VillageCare should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. VillageCare should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended VillageCare continue to pursue provider contracts to expand their provider network.		X	X
Quality-of-Care Survey	VillageCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 298: VNS Health’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	VNS Health’s Response	IPRO’S Assessment of VNS Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VNS Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>VNS Health monitors performance improvement project interventions for continuous quality improvement. Care management workflows now include an annual social determinants of health assessment and embedded social determinants of health questions in call scripts for regular follow-up. VNS Health provides education to providers on the importance of SDOH screening and z-codes for ongoing monitoring and service linkage. VNS Health’s community center collaborates with providers to offer culturally relevant health education and resources for social determinants of health, including food and financial assistance.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>VNS Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, VNS Health should focus on enhancing</p>	<p>VNS Health monitors its performance across the quality measures through real-time dashboards. Linear regression models are used to determine benchmarks which inform measure-level goals that are included in the annual quality workplan. VNS Health reviews performance and initiatives on a weekly basis. When performance falls below the statewide average, VNS Health develops and implements specific interventions to address the</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	VNS Health's Response	IPRO'S Assessment of VNS Health's Response
areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	measure to improve the performance.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
VNS Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. VNS Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	VNS Health has worked to correct areas that were identified as being in need of improvement during the last Department of Health Survey in 2022. Areas that were identified included, but are not limited to, continuing to improve the timeliness of utilization management decisions, revising fiscal intermediary and social adult day care policies, and revising the service authorization and request process as the result of a focused survey. The Compliance Department monitors the corrective actions for alignment with Department of Health requirements.	Addressed.

Performance Improvement Project Summaries and Results

Table 299: VNS Health’s Performance Improvement Project Summary, 2023

VNS Health’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Partial Capitation Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">▪ VNS Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment.▪ VNS Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment.▪ VNS Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted.▪ VNS Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s).
<p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Educated the care management team on Healthify, which provides resources available to aid care managers in linking members to community resources and services not covered by VNS Health.▪ Educated the care management team on the appropriate use of the enhanced social determinants of health assessment and follow-up workflow procedures.
<p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Referred members with diabetes and a positive social determinants of health assessments for home delivered meals.▪ Referred members with diabetes and a positive social determinants of health assessment to social adult day care.▪ Published an article on social determinants of health in the member newsletter.
<p><u>Provider-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Conducted an online course educating provider attendees on Total Over the Counter card and grocery benefits.

Table 300: VNS Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	39.12%	68.52%	85.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	79.85%	85.05%	85.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	12.76%	17.45%	30.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.39%	14.95%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	45.62%	90.44%	65.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 301: VNS Health Partial Capitation Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	87%	84%	68%
No Severe Daily Pain	Not Available	99%	99%	96%
Pain Controlled	Not Available	97%	98%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	75%	78%	78%
Pneumococcal Vaccination	Not Available	80%	86%	80%
COVID-19 Vaccination ³	Not Available	Not Available	84%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 302: VNS Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	C	
438.100: Enrollee Rights	C	
438.114: Emergency and Poststabilization Services	C	
438.206: Availability of Services	NC	NC
438.207: Assurances of Adequate Capacity and Services	C	
438.208: Coordination and Continuity of Care	NC	
438.210: Coverage and Authorization of Services	C	
438.214: Provider Selection	NC	
438.224: Confidentiality	C	
438.228: Grievance and Appeal System	C	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021 Comprehensive	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	NC	
438.236: Practice Guidelines	C	
438.242: Health Information Systems	NC	
438.330: Quality Assessment and Performance Improvement Program	C	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 303: VNS Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
VNS Health failed to meet the minimum requirements for Network Adequacy for required Managed Long-Term Care services.	Managed Long-Term Care Partial Capitation Contract Article VII A.1 Article VII D.2 Article VII D.3 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 304: VNS Health Partial Capitation Network Gaps, Quarter 4 2023

VNS Health Partial Capitation Network Gaps Quarter 4 2023				
Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Adult Day Health Care	11	3	1	2
Audiology Services	17			
Certified Home Health	1	3		
Certified Home Health: Home Based Medical Social Services	1	9		
Certified Home Health: Home Based Occupational Therapy	1	3		
Certified Home Health: Home Based Physical Therapy	1	5		
Fiscal Intermediary	8	2		2
General Dentistry	2	4		
Institutional Long Term Care		5		
Institutional Long Term Care: AIDS Skilled Nursing Facility	1			
Institutional Long Term Care: Vent Skilled Nursing Facility	2	2		
Institutional Short Term Care		3		

VNS Health Partial Capitation Network Gaps Quarter 4 2023

Provider Type With A Gap ¹	Gap Type			
	County Access	County Choice	Surrounding Area Access	Surrounding Area Choice
Licensed Home Health Care: Home Based Medical Social Services	15	10		
Licensed Home Health Care: Home Based Occupational Therapy	1	13		
Licensed Home Health: Home Based Physical Therapy	1	12		
Licensed Home Health Care: Home Based Speech Therapy	1	13		
Optometry	2	1		
Oral Surgery	6	2		
Podiatry	10	7		
Social Day Care	8	5	1	3
Telehealth	18	1	2	5
Therapy: Occupational	6			
Therapy: Physical	2			
Therapy: Speech and Language	6			

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 305: VNS Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	VNS Health Measurement Year 2021	VNS Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	82%	76%	82%
Rating of Dentist	70%	71%	72%
Rating of Care Manager	85%	86%	87%
Rating of Regular Visiting Nurse	77%	83%	84%
Rating of Home Health Aide	92%	92%	93%
Rating of Transportation Services	77%	59%	72%
Timeliness of Home Health Aide	97%	98%	95%
Timeliness Composite	80%	86%	85%
Involved in Decisions	85%	82%	84%
Manage Illness	82%	83%	85%
Access to Routine Dental Care	26%	38%	35%
Same Day Urgent Dental Care	10%	24%	26%
Plan Asked to See Medicines	90%	91%	93%
Talked About Appointing for Health Decisions	82%	76%	74%
Document Appointing for Health Decisions	73%	69%	61%
Plan Has Document Appointing for Health Decisions	79%	83%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 306: VNS Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VNS Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by VNS Health demonstrated improvement between measurement years 2022 and 2023. One performance improvement project indicator rate met and another exceeded VNS Health’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Five performance measure rates calculated by the Department of Health for VNS Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	VNS Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	VNS Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates did not meet VNS Health's 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 review, VNS Health was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	VNS Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	VNS Health performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VNS Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	VNS Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, VNS Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X		X
Compliance with Federal Managed Care Standards	VNS Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. VNS Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Network Adequacy	It is recommended VNS Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	VNS Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Program of All-Inclusive Care for the Elderly Managed Long-Term Care Plans

ArchCare	385
Catholic Health	393
CenterLight	402
Complete Senior Care	411
Eddy SeniorCare	420
ElderONE	429
Fallon Health	437
PACE CNY	446
Total Senior Care	453

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 307: ArchCare’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	ArchCare’s Response	IPRO’S Assessment of ArchCare’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, ArchCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Since the execution of the social determinant of health performance improvement project, ArchCare has implemented an assessment tool, education, and reporting that support the actionable utilization of social determinants of health data, which drive initiatives and interventions. Participants have access to a food card and healthy produce programs which are utilized to improve follow-up after a positive screen. To date, ArchCare continues to exceed the targeted goal of conducting social determinants of health screenings for 75% of all enrolled participants.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>ArchCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ArchCare should focus on enhancing areas of care where its rates are below</p>	<p>ArchCare has a quality improvement program with multiple strategies to address low performance measures and the barriers that drive low performance. Gaps-in-care reports are reviewed and discussed in Quality Assurance Committee meetings and Quality Improvement Workgroups. Rates are monitored to ensure improvement efforts are succeeding as evidenced in the 2022 external quality review, whereby ArchCare exceeded statewide benchmarks. As interventions prove effective, workflows are established for</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	ArchCare's Response	IPRO'S Assessment of ArchCare's Response
the Medicaid Managed Long-term Care program mean.	maintaining person-centered care and performance.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
ArchCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	ArchCare has developed a Quality Assurance and Compliance Program to ensure that they are meeting quality standards, federal, and state regulations. The Quality Assurance Committee meets quarterly to discuss issues and potential resolutions. An interdisciplinary approach is used to include compliance oversight and to stay apprised of any regulatory changes. Internal reviews are steered as ArchCare prepares for the compliance review conducted by the Centers for Medicare and Medicaid Services.	Addressed.

Performance Improvement Project Summaries and Results

Table 308: ArchCare’s Performance Improvement Project Summary, 2023

ArchCare’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Compliance: ArchCare was issued a Statement of Deficiency due to having failed to meet required timeliness deadlines to develop an acceptable quality assurance program.</p> <p>Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly</p>
<p><u>Aim</u></p> <ul style="list-style-type: none"> ArchCare aims to increase screenings for social determinants of health and follow-up for all members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Trained social workers on workflows related to assessments and data collection for all five social determinants of health domains. Created system-generated reports to allow care managers to view member screening for all five social determinants of health domains within the past month.

Table 309: ArchCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	76.00%	70.33%	76.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	64.80%	60.66%	70.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	60.77%	66.18%	75.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	53.47%	14.10%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	86.67%	97.30%	90.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 310: ArchCare Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	87%	85%	68%
No Severe Daily Pain	Not Available	100%	98%	96%
Pain Controlled	Not Available	99%	98%	98%
Not Lonely or Not Distressed	Not Available	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	86%	85%	78%
Pneumococcal Vaccination	Not Available	88%	85%	80%
COVID-19 Vaccination ³	Not Available	Not Available	83%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 311: ArchCare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations		
438.100: Enrollee Rights		
438.114: Emergency and Poststabilization Services		
438.206: Availability of Services	NC	
438.207: Assurances of Adequate Capacity and Services		
438.208: Coordination and Continuity of Care		
438.210: Coverage and Authorization of Services		

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹	2023 Focused ²
438.214: Provider Selection		
438.224: Confidentiality		
438.228: Grievance and Appeal System		
438.230: Subcontractual Relationships and Delegation		
438.236: Practice Guidelines		
438.242: Health Information Systems		
438.330: Quality Assessment and Performance Improvement Program		NC

¹ Provider Network Delivery System Focused Survey.

² Performance Improvement Project Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 312: ArchCare’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
ArchCare failed to meet the minimum requirements for network adequacy for required PACE services.	Medicaid Program of All-Inclusive Care for the Elderly Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206
ArchCare failed to develop an acceptable quality assurance program.	Program of All-Inclusive Care for the Elderly Model Contract Article III Section D., E. Centers for Medicare and Medicaid Services	438.330
ArchCare failed to meet required timeliness deadlines.	Program of All-Inclusive Care for the Elderly Model Contract Article III Section C.	438.330

Network Adequacy Results

Table 313: ArchCare Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

ArchCare Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023	
Provider Type With A Gap ¹	Gap Type
	County Choice
Adult Day Health Care	2

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 314: ArchCare’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	ArchCare Measurement Year 2021	ArchCare Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	88%	79%	82%
Rating of Dentist	63%	65%	72%
Rating of Care Manager	75%	89%	87%
Rating of Regular Visiting Nurse	79%	82%	84%
Rating of Home Health Aide	97%	92%	93%
Rating of Transportation Services	67%	77%	72%
Timeliness of Home Health Aide	96%	92%	95%
Timeliness Composite	88%	87%	85%
Involved in Decisions	72%	82%	84%
Manage Illness	82%	86%	85%
Access to Routine Dental Care	43%	24%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%	26%
Plan Asked to See Medicines	93%	96%	93%
Talked About Appointing for Health Decisions	79%	77%	74%
Document Appointing for Health Decisions	82%	80%	61%
Plan Has Document Appointing for Health Decisions	93%	95%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 315: ArchCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ArchCare’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by ArchCare demonstrated improvement between measurement years 2022 and 2023. One	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	performance improvement project indicator rate exceeded ArchCare's 2023 target rate.			
Performance Measures	Four performance measure rates calculated by the Department of Health for ArchCare for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	ArchCare met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	ArchCare performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates reported by ArchCare demonstrated a decline between measurement years 2022 and 2023. Three of four performance improvement indicator rates did not meet ArchCare's 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2023 review, ArchCare was not in full compliance with two standards reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	ArchCare has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ArchCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	ArchCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ArchCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X		X
Compliance with Federal Managed Care Standards	ArchCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended ArchCare pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	ArchCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Catholic Health

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 316: Catholic Health’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Catholic Health’s Response	IPRO’S Assessment of Catholic Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Catholic Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Catholic Health social workers continue to complete assessments twice per year. Discussions include housing, finances, social support, and access to adequate nutrition. Interventions are developed for the care plan as needed, and any referrals are made. Social workers also call participants monthly. The Catholic Health registered nurse completes a monthly assessment, and other staff members, such as therapists, are in contact with participants on a regular basis. Participants’ needs are identified and addressed as they arise.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Catholic Health should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Catholic Health should focus on enhancing areas of care where</p>	<p>Participants with shortness of breath or pain will continue to be triaged and assessed by clinic and home care registered nurses. Primary care physicians will assess and add new orders. Primary care physicians and therapists will address pain and can add or adjust pain modalities as needed. With reports of being lonely or distressed, a Grand Pad tablet is available for home use. A Grand Pad can help participants stay active, social, and engaged with family and friends. Day center attendance can</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Catholic Health's Response	IPRO'S Assessment of Catholic Health's Response
its rates are below the Medicaid Managed Long-term Care program mean.	be offered or increased if already in place.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Catholic Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	Catholic Health ensures continued compliance with federal and state Medicaid standards. All staff are educated annually and as needed regarding quality and compliance.	Partially addressed.

Performance Improvement Project Summaries and Results

Table 317: Catholic Health’s Managed Long-Term Care Plan Performance Improvement Project Summary, 2023

Catholic Health’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly</p>
<p><u>Aim</u></p> <ul style="list-style-type: none">▪ Catholic Health aims to increase the use of the Accountable Health Communities Health-Related Social Needs screening tool among new and continuing members. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">▪ Educated care managers and social workers on the use and implementation of the Accountable Health Communities Health-Related Social Needs screening tool.▪ Social workers worked with community partners to ensure follow-up for members social determinants of health need(s) (housing insecurity, inadequate food, financial instability, social isolation, and unsafe living situations).▪ Social workers advocated for and worked with community partners to ensure housing security.

Table 318: Catholic Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	100.00%	100.00%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	0.48%	0%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	0.48%	0.54%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 319: Catholic Health Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	44%	44%	68%
No Severe Daily Pain	Not Available	96%	96%	96%
Pain Controlled	Not Available	82%	91%	98%
Not Lonely or Not Distressed	Not Available	89%	94%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	93%	94%	78%
Pneumococcal Vaccination	Not Available	89%	87%	80%
COVID-19 Vaccination ³	Not Available	Not Available	98%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children’s Health Insurance Program Standards Results

Table 320: Catholic Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program	
Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 321: Catholic Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Catholic Health failed to meet the minimum requirements for network adequacy for required Program of All-Inclusive Care for the Elderly services.	Program of All-Inclusive Care for the Elderly Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

No gaps in network adequacy were identified for Catholic Health in Quarter 4 of 2023.

Quality-of-Care Survey Results – Member Experience

Table 322: Catholic Health’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Catholic Health Measurement Year 2021	Catholic Health Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	93%	Sample Size Too Small To Report	82%
Rating of Dentist	81%	Sample Size Too Small To Report	72%
Rating of Care Manager	93%	Sample Size Too Small To Report	87%
Rating of Regular Visiting Nurse	97%	Sample Size Too Small To Report	84%
Rating of Home Health Aide	95%	Sample Size Too Small To Report	93%
Rating of Transportation Services	80%	Sample Size Too Small To Report	72%
Timeliness of Home Health Aide	96%	Sample Size Too Small To Report	95%
Timeliness Composite	93%	Sample Size Too Small To Report	85%
Involved in Decisions	84%	Sample Size Too Small To Report	84%
Manage Illness	89%	Sample Size Too Small To Report	85%
Access to Routine Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	26%
Plan Asked to See Medicines	94%	Sample Size Too Small To Report	93%
Talked About Appointing for Health Decisions	76%	Sample Size Too Small To Report	74%
Document Appointing for Health Decisions	100%	Sample Size Too Small To Report	61%
Plan Has Document Appointing for Health Decisions	96%	Sample Size Too Small To Report	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 323: Catholic Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Catholic Health’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Catholic Health remained static between measurement years 2022 and 2023. Three of four performance improvement project indicator rate exceeded Catholic Health’s 2023 target rates	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Catholic Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Catholic Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement indicator rates did not meet Catholic Health’s 2023 target rates.	X	X	X
Performance Measures	Three performance measure calculated by the Department of Health for Catholic Health for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Catholic Health was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	None.		X	X
Quality-of-Care Survey	None.			
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	In the ongoing performance improvement project, Catholic Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Catholic Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Catholic Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Catholic Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended Catholic Health continue to pursue provider contracts to expand their provider network.		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Catholic Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 324: CenterLight’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	CenterLight’s Response	IPRO’S Assessment of CenterLight’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, CenterLight should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>CenterLight has integrated interventions for social determinants of health disparities into our current performance improvement project on depression. Participants identified with social determinants of health food insecurity are referred to CenterLight’s Nutrition team, and other social determinants of health needs are addressed by social work referrals. CenterLight’s goal is for 100% of identified needs to have a relevant intervention, with an outcome of a 6% increase in participants reporting "No Depressive Feelings" on the Uniform Assessment System for New York - Community Health Assessment, reaching 89.6% by 2025. This is monitored via monthly audits, progress meetings, and site-level reporting.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>CenterLight should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited</p>	<p>CenterLight aims to raise pneumococcal vaccination rates among participants from 67% to 88%. Gaps-in-care are shared with various teams to encourage participant outreach for appointment scheduling and ensuring appointment completion. CenterLight collaborates with uniform assessment system nurses to provide them with real-time data</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	CenterLight's Response	IPRO'S Assessment of CenterLight's Response
<p>access to care, or experienced unfavorable health outcomes. To address this, CenterLight should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>on completed preventive services, improving assessment accuracy. Ongoing education for uniform assessment system nurses ensures effective communication and documentation of responses. Progress is monitored monthly and quarterly.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>CenterLight should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.</p>	<p>As part of CenterLight's audit readiness culture, CenterLight's Compliance Department conducts mock surveys, which was last conducted in June 2024. Staff are randomly selected to answer questions assessing their understanding of policies and procedures, regulations, and roles. CenterLight's goal is to identify and address any potential risks prior to the Centers for Medicare and Medicaid Services interviews. Post-interview, CenterLight's Compliance Department provides feedback on strengths and areas for improvement, with ongoing monitoring to ensure readiness and adherence to standards.</p>	<p>Addressed.</p>

Performance Improvement Project Summaries and Results

Table 325: CenterLight’s Performance Improvement Project Summary, 2023

CenterLight’s Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly Managed Long-Term Care</p>
<p><u>Aims</u></p> <ul style="list-style-type: none">CenterLight aims to increase the percentage of new enrollees with a completed social determinants of health assessment in the first 30 days of enrollment.CenterLight aims to increase the percentage of continuously enrolled participants with a completed social determinants of health assessment.CenterLight aims to increase the percentage of social worker contacts where a social determinants of health screening is conducted.CenterLight aims to decrease the percentage of participants with a documented need resulting from a completed social determinants of health assessment.CenterLight aims to increase the percentage of documented social determinants of health interventions for participants with a need determined by the social determinants of health assessment.
<p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">Educated all social work staff and interdisciplinary team disciplines on methods to present the social determinants of health questions to encourage open and honest responses from participants.Conducted audits on completed social determinants of health assessments to identify suitable interventions for participants.
<p><u>Member-Focused 2023 Interventions</u></p> <ul style="list-style-type: none">Mailed education to participants on the importance of answering the social determinants of health questions openly and honestly to reduce healthcare disparities and improve their quality of life.

Table 326: CenterLight’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022 ¹	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	90.79%	93.82%	94.50%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	99.75%	93.95%	94.50%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	59.05%	72.50%	69.20%
Percentage of members with a positive social determinants of health assessment	No Data To Report	27.33%	13.20%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	98.49%	98.75%	97.50%

¹ The interim measurement period was from May 15th, 2022, to December 31st, 2022.

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 327: CenterLight Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	91%	95%	68%
No Severe Daily Pain	Not Available	100%	99%	96%
Pain Controlled	Not Available	99%	99%	98%
Not Lonely or Not Distressed	Not Available	99%	100%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	85%	89%	78%
Pneumococcal Vaccination	Not Available	67%	68%	80%
COVID-19 Vaccination ³	Not Available	Not Available	91%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 328: CenterLight's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 329: CenterLight’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
CenterLight failed to meet the minimum requirements for Network Adequacy for required Program of All-Inclusive Care for the Elderly services.	Program of All-Inclusive Care for the Elderly Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 330: CenterLight Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

CenterLight Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	1
Institutional Short Term Care	1	
Transportation (Ambulance Service)		1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 331: CenterLight’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	CenterLight Measurement Year 2021	CenterLight Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	84%	76%	82%
Rating of Dentist	70%	63%	72%
Rating of Care Manager	88%	74%	87%
Rating of Regular Visiting Nurse	87%	81%	84%
Rating of Home Health Aide	88%	96%	93%
Rating of Transportation Services	77%	57%	72%
Timeliness of Home Health Aide	94%	95%	95%
Timeliness Composite	85%	83%	85%
Involved in Decisions	78%	76%	84%
Manage Illness	90%	85%	85%
Access to Routine Dental Care	37%	19%	35%
Same Day Urgent Dental Care	20%	8%	26%
Plan Asked to See Medicines	96%	94%	93%
Talked About Appointing for Health Decisions	76%	81%	74%
Document Appointing for Health Decisions	75%	77%	61%
Plan Has Document Appointing for Health Decisions	93%	76%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 332: CenterLight’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	CenterLight’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by CenterLight demonstrated improvement, while a third remained static between measurement years 2022 and 2023. Two of four performance	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	improvement project indicator rates met and exceeded CenterLight's 2023 target rates.			
Performance Measures	Six performance measure rates calculated by the Department of Health for CenterLight for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	CenterLight met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	CenterLight performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Please note that the measurement year 2022 was from May 15 th , 2022, to December 31 st , 2022. Two of four performance improvement indicator rates reported by CenterLight demonstrated a decline between measurement years 2022 and 2023.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for CenterLight for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2023 review, CenterLight was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	CenterLight has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	CenterLight performed significantly worse than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, CenterLight should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	CenterLight should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, CenterLight should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	CenterLight should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended CenterLight pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	CenterLight should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Complete Senior Care

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 333: Complete Senior Care’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Complete Senior Care’s Response	IPRO’S Assessment of Complete Senior Care’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Complete Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Due to staffing changes in the Quality Department at Complete Senior Care, the Accountable Health Communities Social Needs Screening tool was not being completed. Complete Senior Care’s current quality director has reviewed the material and feels this is a necessary project to continue. By the end of 2024, interventions will have been assessed, including barriers from the project, to determine the ongoing process. The social workers on the team will be re-educated, with data analyzed by the end of 2024.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Complete Senior Care should utilize the findings from the Department of Health’s analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Complete Senior Care should focus on enhancing areas of</p>	<p>Complete Senior Care addresses the quality measures of dyspnea, severe daily pain, pain control, and loneliness and distress, at a minimum, initially and semi-annually, as well as throughout the year as needed. If an issue is found, an intervention is put in place, with monitoring until improvement. Vaccines are given in the clinic at routine intervals when they are due. Quality data is tracked on a monthly and quarterly basis and presented to the Quality Committee for further discussion.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Complete Senior Care's Response	IPRO'S Assessment of Complete Senior Care's Response
care where its rates are below the Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Complete Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	On a regular basis, <i>Title 42 Code of Federal Regulations</i> is reviewed by the Director of Quality. Policies and procedures are updated in accordance with updates and changes made to the regulations. Also taken into consideration is New York State's Department of Health regulations around managed long-term care plans. When areas of non-compliance are found, they are immediately corrected.	Addressed.

Performance Improvement Project Summaries and Results

Table 334: Complete Senior Care's Performance Improvement Project Summary, 2023

Complete Senior Care's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly Managed Long-Term Care
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Complete Senior Care aims to improve the percentage of both new and continuously enrolled participants with a completed stand-alone social determinants of health assessment. ▪ Complete Senior Care aims to maintain the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Complete Senior Care aims to decrease the percentage of participants with a positive social determinants of health assessment. ▪ Complete Senior Care aims to improve the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Established protocols to ensure social determinants of health screening occurs at every member assessment. ▪ Developed new workflow to ensure closed-loop process for referring members to community services and supports. ▪ Developed education materials about social determinants of health-related programs and benefits for new and continuously enrolled members.

Table 335: Complete Senior Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	83.87%	89.66%	90.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	85.03%	98.69%	90.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	84.86%	89.47%	90.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	45.95%	42.37%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	65.88%	100.00%	90.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 336: Complete Senior Care Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	25%	23%	68%
No Severe Daily Pain	Not Available	91%	90%	96%
Pain Controlled	Not Available	81%	84%	98%
Not Lonely or Not Distressed	Not Available	55%	47%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	85%	84%	78%
Pneumococcal Vaccination	Not Available	84%	78%	80%
COVID-19 Vaccination ³	Not Available	Not Available	90%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 337: Complete Senior Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards		2023 Focused ¹
438.228: Grievance and Appeal System		
438.230: Subcontractual Relationships and Delegation		
438.236: Practice Guidelines		
438.242: Health Information Systems		
438.330: Quality Assessment and Performance Improvement Program		

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 338: Complete Senior Care’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Complete Senior Care failed to meet the minimum requirements for Network Adequacy for required Program of All-Inclusive Care for the Elderly services.	Program of All-Inclusive Care for the Elderly Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 339: Complete Senior Care Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

Complete Senior Care Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023	
Provider Type With A Gap ¹	Gap Type
	County Choice
Certified Home Health (Home Health Aide)	1
Licensed Home Health Care: Home Based Occupational Therapy	1
Licensed Home Health Care: Home Based Physical Therapy	1
Licensed Home Health Care: Home Based Speech Therapy	1
Oncology and Hematology	1
Private Duty Nursing	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 340: Complete Senior Care’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Complete Senior Care Measurement Year 2021	Complete Senior Care Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	77%	Sample Size Too Small To Report	82%
Rating of Dentist	Sample Size Too Small To Report	Sample Size Too Small To Report	72%
Rating of Care Manager	Sample Size Too Small To Report	Sample Size Too Small To Report	87%
Rating of Regular Visiting Nurse	Sample Size Too Small To Report	Sample Size Too Small To Report	84%
Rating of Home Health Aide	Sample Size Too Small To Report	Sample Size Too Small To Report	93%
Rating of Transportation Services	Sample Size Too Small To Report	Sample Size Too Small To Report	72%
Timeliness of Home Health Aide	Sample Size Too Small To Report	Sample Size Too Small To Report	95%
Timeliness Composite	Sample Size Too Small To Report	Sample Size Too Small To Report	85%
Involved in Decisions	75%	Sample Size Too Small To Report	84%
Manage Illness	Sample Size Too Small To Report	Sample Size Too Small To Report	85%
Access to Routine Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	Sample Size Too Small To Report	26%
Plan Asked to See Medicines	Sample Size Too Small To Report	Sample Size Too Small To Report	93%
Talked About Appointing for Health Decisions	Sample Size Too Small To Report	Sample Size Too Small To Report	74%
Document Appointing for Health Decisions	Sample Size Too Small To Report	Sample Size Too Small To Report	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	Sample Size Too Small To Report	85%

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 341: Complete Senior Care’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Complete Senior Care’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by Complete Senior Care demonstrated improvement between measurement years 2022 and 2023. Two performance improvement project indicator rates met and two exceeded Complete Senior Care’s 2023 target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Complete Senior Care for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Complete Senior Care met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates did not meet Complete Senior Care’s 2023 target rates.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Complete Senior Care for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Complete Senior Care was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Complete Senior Care has the opportunity to reduce their gaps in their network that were		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Complete Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Complete Senior Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Complete Senior Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Complete Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended Complete Senior Care pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Complete Senior Care should	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.			

Eddy SeniorCare

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 342: Eddy SeniorCare’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Eddy SeniorCare’s Response	IPRO’S Assessment of Eddy SeniorCare’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Eddy SeniorCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Eddy SeniorCare has implemented the performance improvement project. Implementation is on target and is continuously incorporated into the day-to-day operational workflows by members of the Interdisciplinary Team. Interdisciplinary Team members implement appropriate interventions as defined by the performance improvement project. Compliance is audited and reported on a quarterly basis to Eddy SeniorCare’s Quality Assurance Performance Improvement Committee. Continuous monitoring of effectiveness is completed by the quality improvement and Interdisciplinary teams, and revisions are made accordingly.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Eddy SeniorCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Eddy</p>	<p>Eddy SeniorCare has incorporated the Managed Long-Term Care New York State Incentive Program Measures (Quality, Satisfaction, and Compliance) into the quality assurance performance improvement program. The quality assurance performance improvement plan includes a wide range of measures (including quality of care, access to care, and health outcomes, in addition to others), targets, and action plans to achieve goals. Progress toward goals is</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Eddy SeniorCare’s Response	IPRO’S Assessment of Eddy SeniorCare’s Response
SeniorCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	assessed quarterly and revisions are made to achieve goals.	
Review of Compliance with Medicaid and Children’s Health Insurance Program Standards		
Eddy SeniorCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	Eddy SeniorCare has a compliance program that meets all compliance program requirements, including internal reviews and audits, to ensure compliance with federal and state Medicaid standards.	Addressed.

Performance Improvement Project Summaries and Results

Table 343: Eddy SeniorCare’s Performance Improvement Project Summary, 2023

Eddy SeniorCare’s Managed Long-Term Care Plan Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p>
<p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p>
<p>Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly</p>
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Eddy SeniorCare aims to complete social determinants of health screening for 90% of newly enrolled members, and 80% of continuously enrolled members at the 6-month assessment period. ▪ Eddy Senior Care aims to have documented interventions for 80% of members who screen positive on social determinants of health assessment. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Built a tool in the electronic medical record to assess five domains of social determinants of health (financial insecurity, safety, social isolation, food insecurity, and housing insecurity) at the time of admission, after six months, and as needs arise. ▪ Trained staff in how to properly document social determinants of health and interventions within the electronic medical record system.

Table 344: Eddy SeniorCare’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	98.59%	98.66%	90.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	87.84%	97.75%	80.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	89.63%	97.97%	30.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	19.40%	17.42%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	99.30%	80.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 345: Eddy SeniorCare Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	50%	45%	68%
No Severe Daily Pain	Not Available	97%	93%	96%
Pain Controlled	Not Available	86%	87%	98%
Not Lonely or Not Distressed	Not Available	91%	91%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	88%	90%	78%
Pneumococcal Vaccination	Not Available	88%	91%	80%
COVID-19 Vaccination ³	Not Available	Not Available	87%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 346: Eddy Senior Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 347: Eddy Senior Care’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Eddy Senior Care failed to meet the minimum requirements for Network Adequacy for required Program of All-Inclusive Care services.	Program of All-Inclusive Care for the Elderly Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 348: Eddy Senior Care Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

Eddy Senior Care Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Inpatient Hospital (Medical Inpatient)		1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 349: Eddy SeniorCare’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	Eddy SeniorCare Measurement Year 2021	Eddy SeniorCare Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	Sample Size Too Small To Report	82%	82%
Rating of Dentist	Sample Size Too Small To Report	81%	72%
Rating of Care Manager	Sample Size Too Small To Report	88%	87%
Rating of Regular Visiting Nurse	Sample Size Too Small To Report	81%	84%
Rating of Home Health Aide	Sample Size Too Small To Report	88%	93%
Rating of Transportation Services	Sample Size Too Small To Report	79%	72%
Timeliness of Home Health Aide	Sample Size Too Small To Report	93%	95%
Timeliness Composite	Sample Size Too Small To Report	90%	85%
Involved in Decisions	Sample Size Too Small To Report	93%	84%
Manage Illness	Sample Size Too Small To Report	86%	85%
Access to Routine Dental Care	Sample Size Too Small To Report	48%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	20%	26%
Plan Asked to See Medicines	Sample Size Too Small To Report	100%	93%
Talked About Appointing for Health Decisions	Sample Size Too Small To Report	84%	74%
Document Appointing for Health Decisions	Sample Size Too Small To Report	91%	61%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	98%	85%

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 350: Eddy Senior Care’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Eddy Senior Care’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Eddy Senior Care demonstrated improvement and the remaining two rates were maintained between measurement years 2023 and 2023. All four performance improvement project indicator rates exceeded Eddy Senior Care’s 2023 target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Eddy Senior Care for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Eddy Senior Care met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	Eddy Senior Care performed significantly better than the Medicaid Managed Long-Term Care program on seven measures of member satisfaction	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Eddy Senior Care for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2023 review, Eddy Senior Care was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Eddy Senior Care has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Eddy Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Eddy Senior Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Eddy Senior Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Eddy Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	compliance review conducted by the Centers for Medicare & Medicaid Services.			
Network Adequacy	It is recommended Eddy Senior Care pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Eddy Senior Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 351: ElderONE’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	ElderONE’s Response	IPRO’S Assessment of ElderONE’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, ElderONE should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>ElderONE continues to monitor all performance improvement projects in a diligent manner and continues to work towards established goals for quality improvement. ElderONE has ongoing evaluations to determine effectiveness of implemented interventions and interventions with high impact are continued to ensure sustainability. Interventions with low impact continue to be revised or eliminated based on the results or barriers.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>ElderONE should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ElderONE should focus on enhancing areas of care where its rates are</p>	<p>ElderONE utilizes findings from Department of Health data to assist in the development of our quality assurance and performance improvement program. ElderONE continues to work towards improving measure rates to ensure participants who have received suboptimal care, to include access to care, and have positive health outcomes. ElderONE continues to focus on enhancing all areas of care where rates are below the Managed Long-Term Care program mean.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	ElderONE's Response	IPRO'S Assessment of ElderONE's Response
below the Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
ElderONE should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	ElderONE continues to ensure compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance reviews conducted by the Centers for Medicare and Medicaid Services.	Addressed.

Performance Improvement Project Summaries and Results

Table 352: ElderONE's Performance Improvement Project Summary, 2023

ElderONE's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ ElderONE aims to maintain a 100% compliance rate for new enrollees who completed a social determinants of health screen within the first 30 days of enrollment. ▪ ElderONE aims to maintain a 100% compliance rate for continuously enrolled members with a completed social determinants of health screen every 6 months. ▪ ElderONE aims to quantify the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ ElderONE aims to decrease the percentage of members with a positive social determinants of health screen. ▪ ElderONE aims to maintain a 100% compliance rate for members with a positive social determinants of health screen with documented interventions to address need(s). <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Implemented a tracking spreadsheet to quantify how many ElderONE participants have a positive social determinants of health screen. ▪ Created and implemented a tracking spreadsheet to be able to quantify how many ElderONE participants who have a positive social determinants of health screen also have documented interventions on their care plan. ▪ Created and implemented a tracking spreadsheet to quantify how many ElderONE participants who report feeling lonely and have documented intervention for day center attendance in their care plan.

Table 353: ElderONE’s Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	98.28%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	99.77%	99.64%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	26.27%	25.60%	50.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	7.18%	2.36%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 354: ElderONE Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	51%	51%	68%
No Severe Daily Pain	Not Available	95%	98%	96%
Pain Controlled	Not Available	92%	96%	98%
Not Lonely or Not Distressed	Not Available	94%	96%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	84%	84%	78%
Pneumococcal Vaccination	Not Available	76%	67%	80%
COVID-19 Vaccination ³	Not Available	Not Available	80%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 355: ElderONE's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards		2023 Focused ¹
438.228: Grievance and Appeal System		
438.230: Subcontractual Relationships and Delegation		
438.236: Practice Guidelines		
438.242: Health Information Systems		
438.330: Quality Assessment and Performance Improvement Program		

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 356: ElderONE’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
ElderONE failed to meet the minimum requirements for Network Adequacy for required Program of All-Inclusive Care services.	Program of All-Inclusive Care Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 357: ElderONE Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

ElderONE Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023	
Provider Type With A Gap ¹	Gap Type
	County Choice
Primary Care Providers	1

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Table 358: ElderONE’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	ElderONE Measurement Year 2021	ElderONE Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	81%	79%	82%
Rating of Dentist	73%	71%	72%
Rating of Care Manager	74%	83%	87%
Rating of Regular Visiting Nurse	89%	88%	84%
Rating of Home Health Aide	84%	80%	93%
Rating of Transportation Services	67%	64%	72%
Timeliness of Home Health Aide	91%	78%	95%
Timeliness Composite	86%	80%	85%
Involved in Decisions	79%	76%	84%
Manage Illness	86%	85%	85%
Access to Routine Dental Care	40%	27%	35%
Same Day Urgent Dental Care	29%	8%	26%
Plan Asked to See Medicines	90%	89%	93%
Talked About Appointing for Health Decisions	83%	78%	74%
Document Appointing for Health Decisions	92%	95%	61%
Plan Has Document Appointing for Health Decisions	98%	96%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 359: ElderONE’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ElderONE’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	Three of four performance improvement project indicator rates reported by ElderONE remained static between measurement years 2022 and 2023. One of four performance improvement project indicator rates met ElderONE’s 2023 target rates.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	One performance measure rate calculated by the Department of Health for ElderONE for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	ElderONE met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	ElderONE performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by ElderOne demonstrated a slight performance decline between measurement years 2022 and 2023. Three of four performance improvement project indicator rates did not reach ElderONE's 2023 target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for ElderOne for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, ElderONE was not in full compliance with one standard reviewed of 42 <i>Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	ElderONE has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	ElderONE performed significantly worse than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ElderONE should diligently monitor its progress towards established goals. At the same time, an	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	ElderONE should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ElderONE should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	ElderONE should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended ElderONE pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	ElderONE should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Fallon Health

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Fallon Health's Response	IPRO'S Assessment of Fallon Health's Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Fallon Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>Fallon Health integrated a social determinants of health screening tool into clinical practice. Fallon continued to review effectiveness of interventions available to address identified resources and connect Program of All-Inclusive Care for the Elderly participants to those resources. One example of high impact resources added for the benefit of PACE participants is additional housing partnerships with assisted living residences.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Fallon Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fallon Health should focus on enhancing areas of care where its rates are</p>	<p>Fallon Health identified influenza immunization as an area of opportunity and focused on a quality improvement initiative to improve influenza immunization, resulting in an improvement to 91.7% of participants immunized for influenza.</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Fallon Health's Response	IPRO'S Assessment of Fallon Health's Response
below the Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Fallon Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	Fallon Health implemented a comprehensive compliance program in 2023 that includes monthly monitoring of key federal and state requirements and implementation of corrective action when established compliance metrics are not met. Fallon Health's Medicare Compliance Officer is responsible for monitoring adherence to the compliance plan.	Addressed.

Performance Improvement Project Summaries and Results

Table 360: Fallon Health’s Performance Improvement Project Summary, 2023

Fallon Health’s Managed Long-Term Care Plan Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Compliance: Fallon Health was issued a Statement of Deficiency due to having failed to meet required timeliness deadlines to develop an acceptable quality assurance program.</p> <p>Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly</p>
<p><u>Aim</u></p> <ul style="list-style-type: none"> Fallon Health aims to increase utilization of a standalone screening tool for social determinants of health in the electronic health record for enrolled participants. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Developed and implemented a standalone tool to capture domains of social determinants of health data and assist with reporting. Educated staff on social determinants of health, criteria recording, and reporting.

Table 361: Fallon Health’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	92.86%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	28.47%	65.91%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	34.39%	71.28%	100.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	100.00%	99.49%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	99.49%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 362: Fallon Health Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	39%	51%	68%
No Severe Daily Pain	Not Available	91%	95%	96%
Pain Controlled	Not Available	76%	93%	98%
Not Lonely or Not Distressed	Not Available	92%	93%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	72%	80%	78%
Pneumococcal Vaccination	Not Available	68%	68%	80%
COVID-19 Vaccination ³	Not Available	Not Available	93%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021. ² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 363: Fallon Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations		
438.100: Enrollee Rights		
438.114: Emergency and Poststabilization Services		
438.206: Availability of Services	C	
438.207: Assurances of Adequate Capacity and Services		
438.208: Coordination and Continuity of Care		
438.210: Coverage and Authorization of Services		

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹	2023 Focused ²
438.214: Provider Selection		
438.224: Confidentiality		
438.228: Grievance and Appeal System		
438.230: Subcontractual Relationships and Delegation		
438.236: Practice Guidelines		
438.242: Health Information Systems		
438.330: Quality Assessment and Performance Improvement Program		NC

1 Provider Network Delivery System Focused Survey.

2 Performance Improvement Project Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 364: Fallon Health’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Fallon Health Weinberg Program of All-Inclusive Care for the Elderly has been reporting that they are conducting timely screening of new and existing members and addressing all identified needs at a rate of essentially 100 percent of the time. Consequently, Fallon Health Weinberg Program of All-Inclusive Care for the Elderly has not developed any interventions to drive improvement. The Department has repeatedly informed Fallon Health Weinberg Program of All-Inclusive Care for the Elderly that if, in fact, is achieving the 100 percent threshold on the key performance indicators, Fallon Health Weinberg Program of All-inclusive Care for the Elderly would be required to present data to support the claim.	Program of All-Inclusive Care for the Elderly Model Contract Article III Section D., E., Centers for Medicare and Medicaid Services Program of All-Inclusive Care for the Elderly Manual Chapter 2, Section 30 Chapter 10, Section 10	438.330

Network Adequacy Results

Table 365: Fallon Health Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

Fallon Health Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023		
Provider Type With A Gap ¹	Gap Type	
	County Access	County Choice
Adult Day Health Care	2	
Anesthesiology Services	1	1
Audiology	1	
Clinical Psychology, Psychology		1
Consumer Directed Personal Care		1
Dermatology	1	
Endocrinology and Metabolism	1	
Family Practice	1	
Fiscal Intermediary	1	
Gastroenterology		1
General Practice	1	
Geriatrics	1	
Home Delivered and Congregate Meals	1	
Inpatient Hospital (Medical Inpatient)	1	
Institutional Short Term Care	2	
Medical Laboratories	2	
Neurology	1	
Neurology Surgery	1	
Ophthalmology	1	
Oral Surgery	1	
Orthopedics	1	
Otolaryngology	1	
Plastic Surgery	1	
Psychiatry		1
Pulmonary Medicine		1
Rheumatology	1	
Social Day Care	1	
Telehealth	2	
Thoracic Surgery	1	1
Transportation (Ambulance Service)	2	
Urology	1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Fallon Health’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 366: Fallon Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fallon Health’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Fallon Health demonstrated improvement and one remained static between measurement years 2022 and 2023.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Fallon Health for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Fallon Health was in compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	Fallon Health met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Fallon Health demonstrated a performance decline between measurement years 2022 and 2023. Four of four performance improvement project indicator rates did not reach Fallon Health’s 2023 target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Fallon Health for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, Fallon Health was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Fallon Health has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fallon Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Fallon Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fallon Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Fallon Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended Fallon Health pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Fallon Health should	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.			

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	PACE CNY's Response	IPRO'S Assessment of PACE CNY's Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, PACE CNY should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>PACE CNY assigns a Social Worker to each participant. Upon enrollment, with re-assessments, and as needed the Social Worker follows the PACE CNY process for assessing the Social Determinants of Health. This is done at a minimum at each regulatory required re-assessment, with significant changes, when requested by participant/family member/care giver.</p>	<p>Partially addressed.</p>
Validation of Performance Measures		
<p>PACE CNY should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, PACE CNY should focus on enhancing areas of care where its rates are</p>	<p>The areas of respiratory status, pain levels, and participant feelings of loneliness or distress are assessed with each regulatory required reassessment. This information is used by the interdisciplinary team to develop a care plan that meets the needs of the participant. Care planning takes place in conjunction with the input from participants/family/caregivers and it mutually agreed upon prior to being established.</p>	<p>Partially addressed.</p>

2022 External Quality Review Recommendation	PACE CNY's Response	IPRO'S Assessment of PACE CNY's Response
below the Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
<p>PACE CNY should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.</p>	<p>The compliance and quality management departments review all pertinent Centers for Medicare & Medicaid Services updates in comparison to current policies, procedures, and practices on an ongoing basis. Our expected goal is to remain in compliance with all state and federal regulatory changes applicable to a Program of All-Inclusive Care for the Elderly plan. The process for monitoring compliance is conducted through auditing regulatory standards which are shared with the organization.</p>	<p>Addressed.</p>

Performance Improvement Project Summaries and Results

Table 367: PACE CNY Performance Improvement Project Summary, 2023

PACE CNY's Performance Improvement Project Summary
<p>Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership</p> <p>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.</p> <p>Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly</p>
<p><u>Aim</u></p> <ul style="list-style-type: none"> PACE CNY aims to demonstrate full compliance with completed social determinants of health assessments. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> Enhanced PACE CNY's new employee orientation program with a segment focusing on the multifaceted approaches to assess and address social determinants of health under the Program of All-Inclusive Care for the Elderly model of care. Updated annual employee orientation to re-engage Program of All-Inclusive Care for the Elderly staff in social determinants of health assessment and care planning interventions.

Table 368: PACE CNY's Performance Improvement Project Indicator Summary, Measurement Years 2021- 2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	100.00%	100.00%	100.00%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	100.00%	100.00%	100.00%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	100.00%	100.00%	100.00%	100.00%
Percentage of members with a positive social determinants of health assessment	100.00%	100.00%	95.12%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	100.00%	100.00%	100.00%	100.00%

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 369: PACE CNY Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	43%	48%	68%
No Severe Daily Pain	Not Available	97%	96%	96%
Pain Controlled	Not Available	95%	95%	98%
Not Lonely or Not Distressed	Not Available	88%	92%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	83%	83%	78%
Pneumococcal Vaccination	Not Available	76%	83%	80%
COVID-19 Vaccination ³	Not Available	Not Available	84%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	
438.228: Grievance and Appeal System	

Part 438 Subpart D Quality Assurance and Performance Improvement	
Program Standards	2023 Focused ¹
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Network Adequacy Results

No gaps in network adequacy were identified for PACE CNY in Quarter 4 of 2023.

Quality-of-Care Survey Results – Member Experience

Table 370: PACE CNY’s Member Satisfaction Results, Measurement Years 2021 to 2023

Measure	PACE CNY Measurement Year 2021	PACE CNY Measurement Year 2023	Medicaid Managed Long-Term Care Measurement Year 2023
Rating of Health Plan	87%	85%	82%
Rating of Dentist	66%	76%	72%
Rating of Care Manager	84%	93%	87%
Rating of Regular Visiting Nurse	83%	91%	84%
Rating of Home Health Aide	79%	84%	93%
Rating of Transportation Services	84%	87%	72%
Timeliness of Home Health Aide	67%	85%	95%
Timeliness Composite	71%	87%	85%
Involved in Decisions	90%	91%	84%
Manage Illness	84%	90%	85%
Access to Routine Dental Care	15%	31%	35%
Same Day Urgent Dental Care	15%	15%	26%
Plan Asked to See Medicines	98%	96%	93%
Talked About Appointing for Health Decisions	84%	83%	74%
Document Appointing for Health Decisions	87%	91%	61%
Plan Has Document Appointing for Health Decisions	90%	96%	85%

Red shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly worse than the Medicaid Managed Long-Term Care program performance.

Green shading indicates that the Medicaid Managed Long-Term Care plan’s performance is significantly better than the Medicaid Managed Long-Term Care program performance.

Strengths, Opportunities for Improvement, and Recommendations

Table 371: PACE CNY's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	PACE CNY's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	All four performance improvement project indicator rates reported by PACE CNY remained static between measurement years 2022 and 2023 at 100% and all four met PACE CNY's 2023 target rate of 100%.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for PACE CNY for measurement year 2023 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2023 review, PACE CNY was in compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330</i> .	X	X	X
Network Adequacy	PACE CNY met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	PACE CNY performed significantly better than the Medicaid Managed Long-Term Care program on six measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for PACE CNY for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	None.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	PACE CNY performed significantly worse than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, PACE CNY should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	PACE CNY should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, PACE CNY should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X		X
Compliance with Federal Managed Care Standards	PACE CNY should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended PACE CNY continue to pursue provider contracts to expand their provider network.		X	X
Quality-of-Care Survey	PACE CNY should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Total Senior Care

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2022 External Quality Review Recommendations

Table 372: Total Senior Care’s Response to 2022 External Quality Review Recommendations

2022 External Quality Review Recommendation	Total Senior Care’s Response	IPRO’S Assessment of Total Senior Care’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Total Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.</p>	<p>After the completion of the 2020-2022 performance improvement project, Total Senior Care identified that the screening tool used for the social determinants of health screening didn't meet the needs of the program. A new screening tool, which includes some aspects of the social determinants of health screening tool, was developed by Total Senior Care’s social work team and implemented. This tool is used with members minimally twice per year. With early detection of potential needs, members will receive improved quality of care which leads to overall improved satisfaction. This tool has also become part of the quality improvement plan.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Total Senior Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Total</p>	<p>Total Senior Care will be revising the quality improvement activity plan to better meet overall program needs. Areas identified with low performance will be the primary focus. Goals and interventions will be established related to these needs. Pertinent staff will be trained on these goals and interventions, and policy changes will be made accordingly. Uniform Assessment System – Community Health Assessment and electronic medical record audits will occur to</p>	<p>Addressed.</p>

2022 External Quality Review Recommendation	Total Senior Care's Response	IPRO'S Assessment of Total Senior Care's Response
Senior Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	ensure data is being captured correctly. Goals and interventions will be adjusted on an as needed basis based on overall performance.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Total Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	Total Senior Care has implemented a survey readiness committee which meets regularly to discuss items related to recent surveys, regulations, completed internal program audits, and results. Any identified concerns are discussed and an internal plan of care is developed to address these concerns. As part of the quality improvement activity plan, Total Senior Care has established a chart audit goal of 10% per quarter to ensure documentation is complete.	Addressed.

Performance Improvement Project Summaries and Results

Table 373: Total Senior Care's Performance Improvement Project Summary, 2023

Total Senior Care's Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership
Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly
<p><u>Aims</u></p> <ul style="list-style-type: none"> ▪ Total Senior Care aims to increase social determinants of health screening rates of all active members. ▪ Total Senior Care aims to increase follow-up rates for identified social determinants of health needs by using clinical and non-clinical interventions. <p><u>Managed Care Plan-Focused 2023 Interventions</u></p> <ul style="list-style-type: none"> ▪ Established protocols to ensure social determinants of health screening occurs at initial assessments and then quarterly for all active members. ▪ Developed new workflows to ensure close-loop process for referring members to community services and supports. ▪ Trained all staff on the prevalence and health impacts of social determinants of health, particularly among the managed long-term care population.

Table 374: Total Senior Care’s Performance Improvement Project Indicator Summary, Measurement Years 2021-2023

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Final Measurement Year 2023	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	76.92%	18.18%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	89.92%	94.53%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	9.03%	17.85%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	23.93%	3.06%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project.

Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results

Table 375: Total Senior Care Program of All-Inclusive Care for the Elderly Performance Measure Results, Measurement Years 2021 to 2023

Measure Description	Measurement Year 2021 ¹	Measurement Year 2022	Measurement Year 2023	Statewide Managed Long-Term Care Average 2023 ²
Preventive Care				
No Shortness of Breath	Not Available	52%	51%	68%
No Severe Daily Pain	Not Available	80%	82%	96%
Pain Controlled	Not Available	89%	78%	98%
Not Lonely or Not Distressed	Not Available	69%	75%	99%
Effectiveness of Care				
Influenza Vaccination	Not Available	66%	69%	78%
Pneumococcal Vaccination	Not Available	65%	68%	80%
COVID-19 Vaccination ³	Not Available	Not Available	83%	76%

¹ Performance data for 2021 is unavailable due to the reassessment moratorium that was in place during 2020 and 2021.

² Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

³ First year measure

Green shading indicates that the managed care plan's 2023 performance is statistically significantly better than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Red shading indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2023 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 376: Total Senior Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program	
Standards	2023 Focused ¹
438.56: Disenrollment: Requirements and Limitations	
438.100: Enrollee Rights	
438.114: Emergency and Poststabilization Services	
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	
438.208: Coordination and Continuity of Care	
438.210: Coverage and Authorization of Services	
438.214: Provider Selection	
438.224: Confidentiality	

Part 438 Subpart D Quality Assurance and Performance Improvement Program	
Standards	2023 Focused ¹
438.228: Grievance and Appeal System	
438.230: Subcontractual Relationships and Delegation	
438.236: Practice Guidelines	
438.242: Health Information Systems	
438.330: Quality Assessment and Performance Improvement Program	

¹ Provider Network Delivery System Focused Survey.

C: Medicaid Managed Long-Term Care plan is in compliance with all standard requirements; NC: Medicaid Managed Long-Term Care plan is not in compliance with at least one standard requirement.

Table 377: Total Senior Care’s Compliance Review Summary of Results, 2023

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Total Senior Care failed to meet the minimum requirements for Network Adequacy for required Program of All-Inclusive Care for the Elderly services.	Program of All-Inclusive Care for the Elderly Contract Article VI E.1 Article VI E.2 Article 44 of the Public Health Law Section 4403-f.5(a)	438.206

Network Adequacy Results

Table 378: Total Senior Care Program of All-Inclusive Care for the Elderly Network Gaps, Quarter 4 2023

Total Senior Care Program of All-Inclusive Care for the Elderly Network Gaps Quarter 4 2023			
Provider Type With A Gap ¹	Gap Type		
	County Access	County Choice	Surrounding Area Access
Dermatology	1	2	
Endocrinology and Metabolism			1
Neurology		1	
Neurology Surgery		1	1
Nutrition		1	
Oncology and Hematology		1	
Ophthalmology		1	
Optometry		1	
Oral Surgery		1	
Plastic Surgery		1	
Transportation (Ambulance Service)		1	
Urology		1	

¹For service area counties that are identified with provider gaps, managed care plans submit a statement of agreement allowing members in those counties to access providers out of network.

Quality-of-Care Survey Results – Member Experience

Total Senior Care’s results from the 2023 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 379: Total Senior Care’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Total Senior Care’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2023.			
	Two of four performance improvement project indicator rates reported by Total Senior Care demonstrated improvement and one remained static between measurement years 2022 and 2023. One of four performance improvement project indicator rates exceeded and one met Total Senior Care’s 2023 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Total Senior Care met the federal requirements for Network Adequacy.		X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Total Senior Care demonstrated a performance decline between measurement years 2022 and 2023. Two of four performance improvement project indicator rates did not reach Total Senior Care’s 2023 target rates.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Total Senior Care for measurement year 2023 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2023 review, Total Senior Care was not in full compliance with one standard reviewed of <i>42 Code of Federal Regulations Part 438 Subpart D</i> .	X	X	X
Network Adequacy	Total Senior Care has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Total Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Total Senior Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Total Senior Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Total Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X
Network Adequacy	It is recommended Total Senior Care pursue provider contracts to reduce the gaps identified		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.			
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Total Senior Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

**Appendix A - Programs of All-Inclusive Care for the Elderly (PACE)
Audit Overview**

Programs of All-Inclusive Care for the Elderly (PACE) Audit Overview

**Medicare Parts C and D Oversight and
Enforcement Group**

Division of Analysis, Policy, and Strategy

I. Executive Summary – PACE Audit Phase Timeline

Phase I: Audit Engagement and Universe / Data Submission

- **Engagement Letter** – CMS notification to PACE organizations of audit selection; identification of audit scope and logistics; and instructions for PACE organizations audit document submissions.
- **Pre-Field Work Meetings** – CMS meetings with PACE organizations to provide information about the audit and documentation request processes, and system access requirements.
- **Pre-Field Work Data Submissions** – PACE organization submission of initial documentation to CMS; the required documentation is identified in the audit protocol and includes universes and other supplemental documentation.
- **Audit Sample Selection** – CMS selection of samples of cases to be tested during field work.

Phase II: Audit Field Work

- **Entrance Conference** – Discussion of CMS audit objectives and expectations; PACE organization optional presentation on organization.
- **Week 1&2 Review** – CMS testing of sample cases via desk/remote review or live webinar review with the PACE organization; CMS requests for additional information and PACE organization responses; PACE organization submission of requested documentation; CMS documentation analyses; and CMS observation of facility, patient care, transportation vehicles, and review of emergency medical equipment.
- **Preliminary Draft Audit Report Issuance** – CMS issuance of a preliminary draft report to PACE organization identifying the preliminary conditions noted during the audit.
- **Exit Conference** – CMS review and discussion of preliminary issues of non-compliance with PACE organization.

Phase III: Audit Analysis and Reporting

- **Condition Classification** – CMS classification of non-compliance.
- **Notification of Immediate Corrective Action Required (ICAR) conditions (as applicable)** – CMS notification to PACE organization of conditions requiring corrective action prior to the issuance of the final report; PACE organization Corrective Action Plan (CAP) submission due within three business days of ICAR notification.
- **Draft Report Issuance** – CMS issuance of draft audit report, inclusive of condition classifications, to PACE organization approximately 60-90 calendar days after the last PACE organization data submission is received.
- **Draft Report Response** – PACE organization submission of comments to the draft report within 10 business days of draft report receipt.
- **Final Report Issuance** – CMS responds to PACE organization comments and updates audit conditions (if applicable); Final report is issued approximately 15-30 calendar days after receipt of the PACE organization's draft report comments.

Phase IV: Audit CAPs and Close Out

- **Non-ICAR Corrective Action Plan (CAP) Submission** – PACE organization submission of CAPs for all conditions classified as a Corrective Action Required within 10 business days of receiving the final audit report.
- **CAP Review and Acceptance** – CMS CAP reasonableness review and notification to PACE organization of acceptance or need for revision.
- **CAP Implementation and Release** – The PACE organization's account manager will provide technical assistance to help ensure the PACE organization is effectively executing corrective action as required. Within 60 days of the final report issuance, CAP implementation is expected and CMS will release the CAPs.
- **Audit Close Out** – Once all CAPs have been released, CMS will close the audit.

II. Background

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) is the group within the Centers for Medicare & Medicaid Services (CMS) responsible for creating and administering the audit strategy for the Programs of All-Inclusive Care for the Elderly (PACE) audits¹. MOEG also oversees, coordinates and conducts the audits of all PACE organizations (POs). These audits measure a PACE organization's compliance with the terms of its contract with CMS, in particular, the regulatory requirements associated with access to services, drugs, and other protections required by Medicare. CMS solicits feedback on the audit process from industry stakeholders through a variety of mediums. CMS uses the feedback to update and improve audit operations as well as to explore new areas that may require oversight.

This document outlines the audit phases for PACE audits. CMS will typically issue engagement letters for scheduled audits from January through September, but this could vary from year to year. Engagement letters for unscheduled audits may be sent at any time throughout the year.

III. Summary of Audit Phases

The PACE audit consists of four phases:

- I. Audit Engagement and Universe/Data Submission
- II. Audit Field Work
- III. Audit Analysis and Reporting
- IV. Audit CAPs and Close Out

The following sections describe important milestones in each phase of the audit.

¹ MOEG also oversees, coordinates, and conducts program audits which includes audits of Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), and Medicare-Medicaid Plans (MMPs). Information regarding program audits is posted on the CMS Program Audits Website located at <https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/programaudits>

Phase I: Audit Engagement and Universe Submission

The Audit Engagement and Universe Submission phase is the six-week period² prior to the field work portion of the audit. During this phase, the PACE organization is notified that it has been selected for an audit and is required to submit the requested data, which is outlined in the PACE audit process and data request document. Key milestones for scheduled audits within Phase I include:

Engagement Letter – CMS issues an audit engagement letter via the Health Plan Management System (HPMS). Notification of the engagement letter is sent to the PACE organization’s Chief Executive Officer - CMS Administrator Contact designated in HPMS. The engagement letter contains instructions for downloading important audit documents from HPMS as well as key dates and timeframes for documentation submission.

Engagement Letter Follow-Up Call – Within two business days from the date of the engagement letter, the CMS audit team conducts a follow-up call with the PACE organization. The purpose of this call is to provide an opportunity for the PACE organization to ask questions about the engagement letter and audit process, as well as for CMS to emphasize important information within the engagement letter and outline next steps in the audit process.

Document Request Log (DRL) and Element Overview Call – Approximately one week after the engagement letter follow-up call, the CMS audit team conducts a call with the PACE organization to discuss the document request process, requests for additional information, medical records systems access requirements, and the review of elements³.

Pre-Audit Issue Summary – Within five business days of the date of the engagement letter issuance, the PACE organization is asked to provide a list of all disclosed issues of non-compliance that are relevant to and may be detected during the audit. A disclosed issue is one that has been reported to CMS prior to the date of the audit engagement letter. Issues identified by CMS or the State Administering Agency through ongoing monitoring or other account management and oversight activities, and/or PACE quarterly data reported during or prior to the audit year, are not considered disclosed. PACE organizations must provide a description of each disclosed issue and the status of correction using the Pre-Audit Issue Summary template. The PACE organization’s account manager will review the template to validate that disclosed issues were reported to CMS prior to receipt of the audit engagement letter.

PACE Supplemental Questions – Within five business days of the date of the engagement letter issuance, the PACE organization is asked to provide responses to the PACE Supplemental Questions document.

² Audit engagement letters are typically issued approximately 45 calendar days prior to the start of audit field work. In some instances, CMS may determine that an unannounced audit is necessary. In these instances, the audit engagement letter may not be issued until near or at the start of audit field work.

³ CMS conducts the DRL and Element overview call with all first-year trial period and routine audits. This call is optional for organizations undergoing second and third-year trial period audits.

Quality and Compliance Documentation Submission – Within 20 business days of the date of the engagement letter, the PACE organization must submit quality improvement plans that were in use during the data collection period, Participant Advisory Committee (PAC) minutes for the data collection period, and documentation demonstrating the measures developed as part of the PO’s compliance oversight program to prevent, detect, and correct noncompliance with regulatory requirements and fraud, waste, and abuse.

Monitoring Reports – Within 20 business days of the date of the engagement letter, the PACE organization must submit monitoring reports for 30 participants, selected by CMS, that detail the organization’s monitoring and tracking of all services across all care settings that were ordered, approved, or care planned during the data collection period.

Universe Submission – Within 20 business days of the date of the engagement letter, the PACE organization must submit all requested universes to CMS following the instructions in the PACE audit process and data request document.

Universe Analysis – CMS will complete data entry tests on all of the universes to ensure there are no blank entries and data is properly formatted. CMS will also analyze universes throughout the audit for varying compliance standards including, but not limited to, the timeliness of service determination requests and appeals. CMS may request revised universes if data issues are identified. PACE organizations will have a maximum of 3 attempts to provide complete and accurate universes, regardless of when the universes are submitted. When multiple attempts are made, CMS will only use the last universe submitted. If the PACE organization fails to provide accurate and timely universe submissions, CMS will document it in the PACE organization’s audit report and this may impact condition classifications.

Audit Sample Selection – CMS selects targeted samples using information submitted by the PACE organization to evaluate during audit field work. Specific sample sizes vary by element and are listed within the PACE audit process and data request document.

Coordination of Audit Field Work – The audit team works with the PACE organization to coordinate, schedule and conduct audit field work; this includes, but is not limited to, coordinating remote access to medical records, scheduling observations, and scheduling meetings with the PACE organization. CMS aims to adhere to the PACE organization’s normal business hours when conducting audit field work activities, but may request alternative hours depending on the progress of audit field work.

Phase II: Audit Field Work

PACE audit field work is typically conducted over a period of two weeks. Key milestones for scheduled audits within Phase II include:

Entrance Conference – Audit field work begins with an entrance conference held on the morning of the first day of field work. The audit lead conducts the meeting, reviews the schedule, and discusses expectations for the audit. The PACE organization will also have an opportunity to make a presentation about its organization.

Notification of Sample Selections – Sample selections for the Service Determination Requests, Appeals and Grievances (SDAG) and Personnel elements will be uploaded to HPMS by the audit team two business days before the reviews of the elements begin. Sample selections for medical record samples will be uploaded to HPMS by the audit team one hour before the review of medical records begins. The audit team will work with the PACE organization to select samples for participant observations; therefore, observation samples will be uploaded to HPMS by the audit team once the observation samples are finalized.

Audit Field Work Weeks 1 and 2 – During field work, the audit team will evaluate sample cases and determine whether the samples are compliant with regulatory requirements. In order to determine compliance, auditors may request additional information and documentation. Auditors may also request that organizations provide supporting documentation for non-compliant or potentially non-compliant cases. PACE organizations must upload all information requested by auditors to HPMS.

The first week of the audit field work typically includes a review of the SDAG, Personnel, and Provision of Services elements, but may also include a review of the Compliance and Quality Improvement element. The review of these elements is accomplished through desk reviews, remote access to the PACE organization's medical records, and when applicable, webinars. The first week of audit field work will also include participant and other observation reviews.

Observations may be conducted in-person or remotely at PACE centers, Alternative Care Settings, and/or participants' homes. The location(s) of observations will be determined by CMS in collaboration with the PACE organization.

During the second week, the audit team will continue to review samples for elements started, but not completed, during the first week of audit field work. Auditors will also conduct a review of the Compliance and Quality Improvement element if not already completed in week one. The review of the Compliance and Quality Improvement element is typically conducted remotely, via webinar.

CMS may extend the duration of field work beyond two weeks to accommodate holidays or when additional time is needed to complete the review of samples and/or to collect additional information or documentation from the PACE organization.

Daily Debriefs – The purpose of the debrief is to inform PACE organization staff of the status of the audit, review potential conditions of non-compliance identified in sample cases, and address any questions staff may have. Debriefs will be held on a daily basis during the audit field work phase, unless there is no new information, status updates, or questions to discuss or the organization requests not to hold the debrief meeting.

Root Cause Analysis Submissions – A root cause analysis must be submitted, as requested by auditors, for all non-compliance identified during the audit. CMS may also require organizations to submit a completed root cause analysis for any disclosed issue of non-compliance. The PACE organization's root cause analysis must identify the core problem(s) or issue(s) that resulted in non-compliance with regulatory requirements and a description of why the non-compliance occurred. Root cause analyses are due within 24 to 48 hours of the request (depending on the number requested) and must be uploaded to the HPMS as instructed by CMS. CMS may grant additional time when requested by the organization. CMS will attempt to request all root cause analyses prior to the exit conference; however, CMS reserves the right to make requests after the exit conference has

concluded. CMS will review the submission and instruct the PACE organization on next steps for completing an impact analysis, as applicable.

Issuance of Preliminary Draft Audit Report – At the conclusion of the audit field work phase, CMS will issue a preliminary draft audit report to the PACE organization, identifying conditions noted during the audit as of the exit conference. The audit lead issues this report via the HPMS prior to the exit conference. Please note that additional conditions may be added as a result of Root Cause Analyses, Impact Analyses or other submitted data.

Exit Conference – The final day of field work concludes with an exit conference. The audit team will walk through the preliminary conditions of non-compliance with the PACE organization and discuss any outstanding requests for information. During the exit conference, the PACE organization may ask questions about the findings and provide any follow-up information as appropriate. Preliminary conditions of non-compliance are subject to additional review and evaluation after the exit conference when all supporting documentation and requested analyses have been received and evaluated. Classification of conditions will occur once the review and evaluation of all documentation is completed. PACE organizations will have an opportunity to formally respond or provide comments for CMS’s consideration during the draft audit report process.

Impact Analysis Submissions – CMS may request impact analyses for conditions identified during the audit in order to determine the scope of non-compliance. CMS may also require organizations to submit a completed impact analysis for any disclosed issue of non-compliance. The impact analysis must identify the participants or personnel subject to or impacted by the issue of non-compliance as instructed by CMS. Within 10 business days of the request or the date of the exit conference (whichever is later), PACE organizations must upload the impact analyses to the HPMS as instructed by CMS. CMS may grant additional time when requested by the organization. CMS may validate the accuracy of the impact analysis submission(s). In the event an impact analysis cannot be produced, is incomplete, or is invalidated, CMS will report that the scope of the non-compliance could not be fully measured and impacted an unknown number of participants/personnel during the audit review period.

Phase III: Audit Analysis and Reporting

Audit analyses and reporting occurs in multiple stages beginning with the findings identified and discussed during the audit field work stage (i.e., daily debriefs, exit conference) and through root cause/impact analysis requests, followed by more formal notification of conditions classified as Immediate Corrective Action Required (ICAR) and issuance of the draft and final reports. Key milestones for scheduled audits within Phase III include:

Root Cause/Impact Analysis Submission and Validation – PACE organizations submit remaining requested root cause and impact analyses. Audit team members review and analyze submitted impact analyses to determine the effect of non-compliance. If CMS believes that one or more impact analyses may be incomplete or inaccurate, CMS may validate the accuracy of the impact analysis submission(s) and may require the organization to submit additional case files or provide access to additional participant medical records.

Condition Classification – Upon receipt of all audit documentation, auditors meet with the PACE Audit Consistency Team (PACT). The PACT serves as subject matter experts for PACE and audit policy and ensures consistency in classification of audit conditions across all audits in accordance with the following definitions:

- **Immediate Corrective Action Required (ICAR)** – An ICAR is a deficiency that requires prompt correction prior to the issuance of the final report. These conditions of non-compliance result in a lack of access to care and/or services, may pose an immediate threat to participant health and safety, and/or result in harm or the potential for harm. Situations that restrict, hinder, or limit a participant’s ability to request or advocate for care and/or services are considered a lack of access to care or services⁴.
- **Corrective Action Required (CAR)** – A CAR is a deficiency that must be corrected, but the correction can wait until the final audit report is issued. These issues may impact participants, but are not of a nature that immediately affects their health and safety or their ability to advocate for care and/or services. Generally, they involve deficiencies with respect to lacking or inadequate policies and procedures, systems, internal controls, training, operations, or staffing.
- **Observations** – Observations are conditions of non-compliance that do not require submission of a corrective action plan based on the nature of the deficiency and why the deficiency occurred. For example, conditions may be classified as observations when only one instance of non-compliance is identified and the non-compliance occurred as a result of human error. Although CMS does not require the submission of corrective action plans for observations, CMS does expect PACE organizations to ensure the non-compliance is addressed and corrected.

Referral for Enforcement Action – Conditions noted in the audit may be referred to the Division of Compliance Enforcement (DCE). DCE will conduct an independent review of audit documentation to determine if an enforcement action (Civil Money Penalty, sanction, or contract termination) is warranted.

Notification of Immediate Corrective Action Required (ICAR) Conditions – If one or more conditions are classified as an ICAR, the PACE organization will receive notification and prompt corrective action must be implemented in order to remediate non-compliant activity and prevent

⁴ If CMS determines that a disclosed issue was promptly identified, corrected, and the risk to participants has been mitigated, CMS may not apply the Immediate Corrective Action Required classification to that condition. CMS may require organizations to submit a completed root cause analysis and/or impact analysis for any disclosed issue of non-compliance.

future non-compliance. This notification typically is issued in advance of the draft audit report, but may occur with the draft audit report. PACE organizations are required to submit Corrective Action Plans describing the actions taken to remediate non-compliance within three business days of being informed of the ICAR condition.

Draft Audit Report Preparation and Issuance to the PACE Organization – CMS prepares a draft audit report (inclusive of condition classifications) with a target for issuance between 60 and 90 calendar days from the date of the last data submission received from the PACE organization.

Draft Report Response – The PACE organization has 10 business days to respond to the draft audit report with comments to CMS. This is an organization’s opportunity to request reconsideration of a condition or classification. CMS reviews and responds to any comments the PACE organization submits in the HPMS and determines if the comments warrant a change in the final audit report.

Issuance of the Final Audit Report – CMS aims to issue the final audit report between 15 and 30 calendar days from receipt of the PACE organization’s comments to the draft audit report. The final report contains the final classification of conditions noted during the audit. There is no additional opportunity to comment on the conditions of non-compliance after this report is issued.

Audit Feedback – Following issuance of the final audit report, CMS will send PACE organizations an optional audit survey. CMS will use feedback collected from the survey to improve the PACE audit process.

Phase IV: Audit CAPs and Close Out

The final phase of the PACE audits occurs over a period of approximately 60 to 90 days. Once the final audit report is issued, PACE organizations develop, implement, and monitor corrective action plans. Key milestones for scheduled audits within Phase IV include:

Non-ICAR Corrective Action Plan (CAP) Submission – PACE organizations have 10 business days from the issuance of the final audit report to submit CAPs associated with conditions classified as Corrective Action Required.

CAP Review and Acceptance – Upon receipt of the CAPs, CMS performs a reasonableness review and notifies the PACE organization of either CAP acceptance or the need for additional information. CMS continues the reasonableness review process until it deems all CAPs acceptable.

CAP Implementation and Release – CMS requires that PACE organizations undertake correction of conditions noted in the final audit report. The PACE organization’s account manager will provide technical assistance and education to help the organization ensure that their implemented corrective actions will effectively address non-compliance. This may include collection and review of documentation submitted by the organization. Corrective action plans will be released 60 days after CAPs acceptance by CMS with the expectation that PACE organizations will have fully implemented those corrective action plans by that time.

Audit Close Out – Once CAPs are released, CMS will close the audit and send an audit close out letter to the PACE organization. The PACE organization should continue to monitor the implemented corrective actions to ensure and maintain full compliance with CMS requirements.