



New York State Medicaid Managed Long-Term Care 2024 External Quality Review Annual Technical Report

Medicaid Advantage Plus Plans

Partial Capitation Plans

Program of All-Inclusive Care for Elderly Plans

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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 2024.

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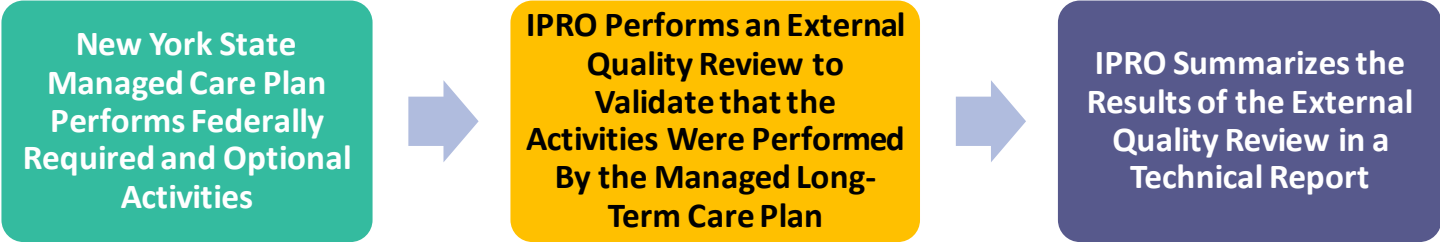
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About This Report

The Balanced Budget Act of 1997 requires that state agencies contracting with Medicaid managed care 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 2024 external quality review of the managed care plans that comprised New York’s Medicaid managed care 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 standards, and validation of network adequacy that were conducted between January 1, 2024, and December 31, 2024, or measurement year 2024.

Table 1: Managed Long-Term Care External Quality Review Activities Performed for 2024

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 decreasing rates of depression.	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.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care 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* set forth the requirements for the annual external quality review of contracted managed care plans. (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 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.¹ 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, PIHP², PAHP³, or PCCM⁴ 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 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.

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 2024 external quality review of the managed care plans that are part of New York’s Managed Long-Term Care program.

2024 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

¹ The Centers for Medicare & Medicaid Services website: <https://www.cms.gov/>.

² prepaid inpatient health plan.

³ prepaid ambulatory health plan.

⁴ primary care case management.

standards, and validation of network adequacy) that were conducted for measurement year 2024. IPRO’s external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*⁵ 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 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.
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.

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

⁵ The Centers for Medicare & Medicaid Services External Quality Review Protocols website: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf> .

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.⁶ 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 2024:

- 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 plans are compliant with regulatory standards and have committed adequate resources to perform internal

⁶ Medicaid.gov About 1115 Demonstrations Website: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> .

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 Strategy⁷ 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 **Table 3**.

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

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

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).

⁷ 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

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
12. Improve access to and quality of Home and Community Based Services	X	X	X		X	X	X	X
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	Measurement Year 2024	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%	9%	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	Non-Survey Year	85%
	Child CAHPS: Getting Care Quickly (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2020	88%	Non-Survey Year	85%	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%	17%	15%
4. Support members in their communities	Quality of Home Health Aide/Personal Care Aide (Medicaid Managed Long-Term Care)	2021	91%	91%	Non-Survey Year	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	3 %	20%
6. Improve the health and safety of members’ environments	No Falls Injury (Medicaid Managed Long-Term Care)	2022	92% ³	93%	93%	91%
7. Promote a sustainable provider workforce and capacity	Medicaid Enrolled Dentists (New York State Licensed Dentists)	2022	42%	41%	35%	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%	65%	67.5%

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Measurement Year 2024	Target by 2025
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%	35%	33%
	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%	47%	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 ⁴	51%	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 ⁴	66%	69%
10. Improve access to and quality of dental care	Topical Fluoride for Children (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2023	17%	17%	17%	19%
	Adult Annual Dental Visit (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan, Medicaid Fee-For-Service)	2021	20%	19%	24%	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%	87%	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% ⁵	80% ⁶	92% ⁷	85% ⁸

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Measurement Year 2024	Target by 2025
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%	62%	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%	76%	73%
	Child and Adolescent Well-Care Visits (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	70%	70%	73%	71%
	Follow-Up Care for Children Prescribed ADHD Medication – Initiation ⁹ (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	53%	56%	58%	55%
	Follow-Up Care for Children Prescribed ADHD Medication – Continuation ⁹ (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)	2021	62%	62%	63%	63%
15. Improve access to and quality of chronic disease management	Viral Load Suppression (Mainstream Medicaid Managed Care, Child Health Plus)	2021	73%	75%	78%	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%	64%	57%
	Asthma Medication Ratio (Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, Health and Recovery Plan)	2021	55%	71%	76%	56%
16. Increase utilization of preventive healthcare services	Colorectal Cancer Screening ¹⁰ (Mainstream Medicaid, HIV Special Needs Plan, Health and Recovery Plan)	2021	61%	51%	55%	62%
	Childhood Immunization Status - Combination 10 ¹⁰	2021	42%	34%	31%	43%

Objective	Metric (Population)	Baseline Measurement Year	Baseline Measurement Rate	Measurement Year 2023	Measurement Year 2024	Target by 2025
	(Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan)					
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%	70%	74%	79%
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%	83%	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%	30%	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%	62%	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%	78%	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	8.26 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 originally posted Quality Strategy included a baseline rate of 90%, representing the population for which demographic data was available for stratification. This report uses the baseline rate of 92% which aligns with other publicly reported data for this measure.

⁴ 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.

⁵ This measure is calculated based on the state fiscal year (April-March). The Baseline Measurement Year rate is from April 2021-March 2022.

⁶ This measure is calculated based on the state fiscal year (April-March). The Measurement Year 2023 rate is from April 2022-March 2023.

⁷ This measure is calculated based on the state fiscal year (April-March). The Measurement Year 2024 rate is from April 2023-March 2024.

⁸ This measure is calculated based on the state fiscal year (April-March). The Target Measurement Year 2025 rate is from April 2024-March 2025.

⁹ The Baseline Measurement Year rate was calculated using administrative methodology, and the Measurement Year 2023 rate was calculated using electronic methodology.

¹⁰ 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 ambulance providers to transport to locations other than the emergency department, and pursuing the continuation of treatment in place that had previously been allowable under the federal Emergency Triage, Treat, and Transport model. 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*⁸. 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.

⁸ Children's Health Insurance Program standards at *Title 42 Code of Federal Regulations 457.1240(e)* cross-reference to the Medicaid managed care State quality strategy requirements at *Title 42 Code of Federal Regulations 438.340*.

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 2024, 15 metrics have either met or exceeded the 2025 targets. Focus areas that exceeded target performance included ensuring coordinated care and promoting integrated care, improving the health and safety of member's environments, improving access to and quality of: behavioral healthcare, dental care, maternal healthcare, home and community based services, care for infants and children, and chronic disease management, and promoting data-driven Medicaid oversight and health plan accountability. One metric was not collected as 2024 was a non-survey year for Adult CAHPS.

Despite early positive outcomes, continued opportunities for enhancing health outcomes under the current strategy exist statewide. Eleven metrics that decreased from baseline year 2021 or remain unchanged include: *Medicaid Enrolled Dentists*, *Proportion of Members in a Patient-Centered Medical Home*, *Follow-Up After Emergency Department Visit for Mental Illness - 7 Day*, *Follow-Up After Emergency Department Visit for Mental Illness - 30 Day*, *Proportion of Members who Utilize Primary Care*, *Colorectal Cancer Screening*, *Childhood Immunization Status - Combination 10*, *Pharmacotherapy for Opioid Use Disorder*, *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)*⁹, 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 targets set for 2025 for the metrics that were already met and exceeded in measurement year 2024.
- The Department of Health should continue 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.
- The Department of Health should consider strategies to increase the state's capacity of Medicaid enrolled dentists to reach their target for 2025. The Department of Health should also consider strategies to increase membership's utilization of primary care.
- The Department of Health should continue member, provider, and Managed Care Plan outreach to improve access to and quality of behavioral healthcare and reduce unnecessary emergency room visits and hospitalizations for mental illness.
- Overall, performance measurement is progressing towards target goals at this year 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.

⁹ Children's Health Insurance Program standards at *Title 42 Code of Federal Regulations 457.1250 (a)* cross-reference to the Medicaid managed care External quality review results requirements at *Title 42 Code of Federal Regulations 438.364 (a)(4)*.

- 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. As of December, 2024, there were 12 approved Medicaid Advantage Plus plans (11 of the plans with enrollment); 20 Partial Capitation plans (14 of the plans with enrollment); and 9 Program of All-Inclusive Care for the Elderly plans (all 9 plans had enrollment). Descriptions of the Managed-Long Term Care plan types are in **Table 6**.

In New York State Fiscal Year 2023-2024, a statute was passed in May 2023 that required Partial Capitation Managed Long Term Care plans to have an active Centers for Medicare & Medicaid Services-approved Designated-Special Needs Plan in place by January 1, 2024. In June 2023, all Partial Capitation plans were communicated that if their plan did not have a Centers for Medicare & Medicaid Services-approved and active Designated-Special Needs Plan in place by January 1, 2024, the Partial Capitation plan was required to merge with or be acquired by another Partial Capitation plan that did have an active Designated-Special Needs Plan in place or to withdraw from the Partial Capitation line of business. This work continued into 2024 and the following plans merged or withdrew:

- Evercare Choice, Inc. (EverCare) was acquired by Elderplan, Inc. (HomeFirst) effective May 1st, 2024.
- Prime Health Choice, LLC (Prime Health) was acquired by VNS Choice (VNS Health Choice) effective May 1st, 2024.
- Niagara Advantage Health Plan, LLC (Elderwood Health Plan) was acquired by VNS Choice (VNS Health Choice) effective May 1st, 2024.
- Senior Network Health, LLC was acquired by VNS Choice (VNS Health Choice) effective June 1st, 2024.
- Archcare Community Life (Archcare) was acquired by Village Senior Services Corp (VillageCareMAX) on June 1st, 2024.
- Kalos Health, Inc. was acquired by VNS Choice (VNS Health Choice) effective December 1st, 2024.

The remaining Partial Capitation plans that did not have active Designated -Special Needs Plan in place for 2024, submitted letters of intention to open a Medicaid Advantage Plus line of business, merge or be acquired in calendar year 2025.

In all cases, plans' membership were notified of these transactions 60 days in advance and were given instructions to voluntarily choose another plan in their service area or would be auto transferred to the acquiring plan or in the case of a plan withdrawal, to voluntarily choose another plan or be auto assigned to another plan.

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; and b. 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 providers. 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.

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 2024.

Table 7: Managed Long-Term Care Profiles

Managed Long-Term Care Plan	Enrollment as of 12/2024 ¹
Medicaid Advantage Plus	53,384
Anthem HP, LLC [Anthem HealthPlus Dual Plus (HMO D-SNP)]	203
Centers Plan for Healthy Living, LLC (Centers Plan for Healthy Living)	1,831
Elderplan, Inc. (Elderplan)	4,973
ElderServe Health, Inc. (ElderServe MAP)	399
Hamaspik Inc. (Hamaspik)	1,022
Healthfirst Health Plan, Inc. (Healthfirst CompleteCare)	33,737

Managed Long-Term Care Plan	Enrollment as of 12/2024 ¹
MetroPlus Health Plan, Inc (MetroPlus Ultra Care)	231
New York Quality Healthcare Corporation [Wellcare Fidelis Dual Plus (HMO D-SNP)]	1,918
Senior Whole Health of New York Inc. (Senior Whole Health)	282
United Healthcare Dual Complete (United Healthcare) ²	No Enrollment
Village Senior Services Corp. (VillageCareMAX Medicare Total Advantage)	3,752
VNS Choice (VNS Health Total)	5,036
Partial Capitation	310,583
Aetna Better Health Inc. (Aetna Better Health)	6,619
Anthem HP, LLC (Anthem Blue Cross and Blue Shield HP MLTC)	62,184
Archcare Community Life (Archcare) ³	No Enrollment
Center Plan for Healthy Living, LLC. (Centers Plan for Healthy Living)	54,381
Elderplan, Inc. (HomeFirst)	27,623
ElderServe Inc. (RiverSpring at Home)	20,089
EverCare Choice, Inc. (EverCare) ⁴	No Enrollment
Hamaspik Choice, Inc. (Hamaspik Choice)	8,440
Healthfirst PHSP, Inc. (Senior Health Partners)	10,577
iCircle Care (iCircle)	4,547
Kalos Health Inc. ⁵	No Enrollment
MetroPlus Health Plan, Inc. (MetroPlus Health)	2,731
New York Quality Healthcare Corporation (Fidelis Care at Home)	20,150
Niagara Advantage Health Plan, LLC (Elderwood Health Plan) ⁶	No Enrollment
Prime Health Choice, LLC (Prime Health) ⁷	No Enrollment
Senior Network Health, LLC (Senior Network Health) ⁸	No Enrollment
Senior Whole Health of New York Inc.(Senior Whole Health)	27,221
Village Senior Services Corp. (VillageCareMAX)	31,751
VNA HomeCare Options, LLC. (Nascentia Health Options)	6,669
VNS Choice (VNS Health Choice)	27,601
Program of All-Inclusive Care for the Elderly	9,994
Catholic Health System PACE (Catholic Health-LIFE)	242
Catholic Managed Long Term Care, Inc (ArchCare Senior Life)	849
CenterLight Healthcare PACE (CenterLight)	6,654
Complete Senior Care, Inc. (Complete Senior Care)	139
Eddy SeniorCare	421
Fallon Health Weinberg-PACE (Fallon Health)	195
Independent Living for Seniors dba ElderONE (ElderONE)	768
PACE CNY	603
Total Senior Care, Inc. (Total Senior Care)	123

¹ Data Sources: New York State Department of Health Managed Long-Term Care Plan Directory, Revised August 2025. 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 2024. Website: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

² United Healthcare was established in 2024 but had no enrollment until May of 2025.

³ Archcare was acquired by VillageCareMAX effective 6/1/2024.

⁴ EverCare was acquired by HomeFirst effective 5/1/2024.

⁵ Kalos Health, Inc. was acquired by VNS Health Choice effective 12/1/2024.

⁶ Elderwood Health Plan was acquired by VNS Health Choice effective 5/1/2024.

⁷ Prime Health was acquired by VNS Health Choice effective 5/1/2024.

⁸ Senior Network Health was acquired by VNS Health Choice effective 6/1/2024.

Since the Measurement Year 2023 Annual Technical Report, some Managed Long-Term Care plans have had name changes. **Table 8** displays the names used in the measurement year 2023 Annual Technical Report cross referenced to the names used in this year’s Annual Technical Report.

Table 8: Managed Care Plan Names, Measurement Years 2023 and 2024

Managed Long-Term Care Plan	
Measurement Year 2023 Plan Name	Measurement Year 2024 Plan Name
Medicaid Advantage Plus	
Empire Blue Cross Blue Shield HealthPlus Duals Plus (Empire BCBS HealthPlus)	Anthem HP, LLC [Anthem HealthPlus Dual Plus (HMO D-SNP)]
Centers Plan for Medicaid Advantage Plus (Centers Plan)	Centers Plan for Healthy Living, LLC (Centers Plan for Healthy Living)
Elderplan, Inc. MAP (Elderplan)	Elderplan, Inc. (Elderplan)
RiverSpring MAP (RiverSpring)	ElderServe Health, Inc. (ElderServe MAP)
Hamaspik Inc. (Hamaspik)	Hamaspik Inc. (Hamaspik)
MHI Healthfirst CompleteCare (MHI Healthfirst)	Healthfirst Health Plan, Inc. (Healthfirst CompleteCare)
MetroPlus Ultracare (MetroPlus)	MetroPlus Health Plan, Inc (MetroPlus Ultra Care)
Fidelis Medicaid Advantage Plus (Fidelis Care)	New York Quality Healthcare Corporation [Wellcare Fidelis Dual Plus (HMO D-SNP)]
Senior Whole Health of New York MAP (Senior Whole Health)	Senior Whole Health of New York Inc. (Senior Whole Health)
Not in operations in measurement year 2023	United Healthcare Dual Complete (United Healthcare) ²
VillageCareMAX Medicare Total Advantage (VillageCare)	Village Senior Services Corp. (VillageCareMAX Medicare Total Advantage)
VNS Health Total (VNS Health)	VNS Choice (VNS Health Total)
Measurement Year 2023 Plan Name	Measurement Year 2024 Plan Name
Partial Capitation	
Aetna Better Health (Aetna)	Aetna Better Health Inc. (Aetna Better Health)
Empire Blue Cross Blue Shield HealthPlus MLTC (Empire BCBS HealthPlus)	Anthem HP, LLC (Anthem Blue Cross and Blue Shield HP MLTC)
ArchCare Community Life (ArchCare)	Archcare Community Life (Archcare) ³
Centers Plan for Healthy Living (Centers Plan)	Center Plan for Healthy Living, LLC. (Centers Plan for Healthy Living)
HomeFirst, a product of Elderplan, Inc. (Elderplan)	Elderplan, Inc. (HomeFirst)
RiverSpring at Home (RiverSpring)	ElderServe Inc. (RiverSpring at Home)
EverCare Choice (EverCare)	EverCare Choice, Inc. (EverCare) ⁴
Hamaspik Choice, Inc. (Hamaspik)	Hamaspik Choice, Inc. (Hamaspik Choice)
Senior Health Partners a Healthfirst Company (Senior Health Partners)	Healthfirst PHSP, Inc. (Senior Health Partners)
iCircle Care (iCircle)	iCircle Care (iCircle)

Managed Long-Term Care Plan	
Kalos Health	Kalos Health Inc. ⁵
MetroPlus MLTC (MetroPlus)	MetroPlus Health Plan, Inc. (MetroPlus Health)
Fidelis Care at Home (Fidelis Care)	New York Quality Healthcare Corporation (Fidelis Care at Home)
Elderwood Health Plan (Elderwood)	Niagara Advantage Health Plan, LLC (Elderwood Health Plan) ⁶
Prime Health Choice, LLC (Prime Health)	Prime Health Choice, LLC (Prime Health) ⁷
Senior Network Health, LLC (Senior Network Health)	Senior Network Health, LLC (Senior Network Health) ⁸
Senior Whole Health of New York MLTC (Senior Whole Health)	Senior Whole Health of New York Inc.(Senior Whole Health)
VillageCareMAX (VillageCare)	Village Senior Services Corp. (VillageCareMAX)
Nascentia Health (Nascentia)	VNA HomeCare Options, LLC. (Nascentia Health Options)
VNS Health MLTC (VNS Health)	VNS Choice (VNS Health Choice)
Measurement Year 2023 Plan Name	Measurement Year 2024 Plan Name
Program of All-Inclusive Care for the Elderly	
Catholic Health-LIFE (Catholic Health)	Catholic Health System PACE (Catholic Health-LIFE)
ArchCare Senior Life (ArchCare)	Catholic Managed Long Term Care, Inc (ArchCare Senior Life)
CenterLight Healthcare PACE (CenterLight)	CenterLight Healthcare PACE (CenterLight)
Complete Senior Care	Complete Senior Care, Inc. (Complete Senior Care)
Eddy SeniorCare	Eddy SeniorCare
Fallon Health Weinberg-PACE (Fallon Health)	Fallon Health Weinberg-PACE (Fallon Health)
Independent Living for Seniors dba ElderONE (ElderONE)	Independent Living for Seniors dba ElderONE (ElderONE)
PACE CNY	PACE CNY
Total Senior Care, Inc. (Total Senior Care)	Total Senior Care, Inc. (Total Senior Care)

External Quality Review Activity 1. Validation of Performance Improvement Projects

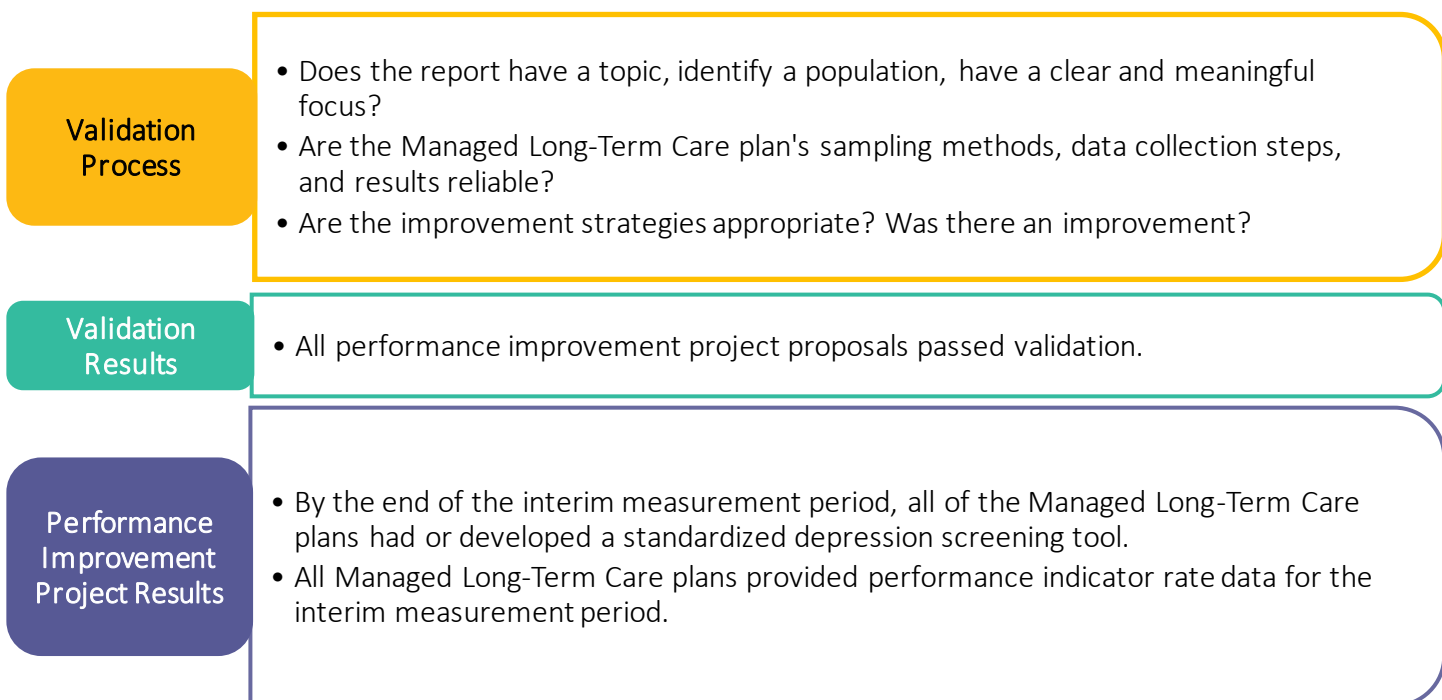
Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy

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 2024, the Managed Long-Term Care performance improvement project topic was Improving Rates of Depression Screening for the Managed Long-Term Care General Membership.

2024 Performance Improvement Projects Summary



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 438.358 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 Depression Screening for the Managed Long-Term Care General Membership* performance improvement projects that were initiated on January 1, 2024.

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 VIII(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 2024 and continuing through 2025 the Managed Long-Term Care plans are required to conduct the performance improvement project: *Improving Rates of Depression Screening for the Managed Long-Term Care General Membership*.

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 Depression Screening for the Managed Long-Term Care General Membership* project aims to increase managed care plan screening and follow-up related to depression among the Managed Long-Term Care population. Descriptions of the five required performance indicators are in **Table 9**.

Table 9: Required Performance Improvement Project Indicators, 2024-2025

Indicator	Numerator	Denominator
Percentage of members reporting no depressive feelings	Number of continuously enrolled ¹ members who reported no depressive feelings	Number of continuously enrolled ¹ members
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Number of continuously enrolled ¹ members who reported depressive feelings and had a follow-up positive screen using a standardized depression screening tool	Number of continuously enrolled ¹ members who reported depressive feelings
Percentage of positive depression screens that have a documented intervention	Number of positive depression screens completed by continuously enrolled ¹ members using a standardized depression screening tool on or after January 1 through December 15 of the measurement year and have a documented intervention within two weeks (14 days) of the initial screening	Number of positive depression screens using a standardized depression screening tool from continuously enrolled ¹ members which were completed on or after January 1 through December 15 of the measurement year
Percentage of positive depression screens with follow-up	Number of positive depression screens completed by continuously enrolled ¹ members using a standardized depression screening tool on or after January 1 through November 1 of the measurement year with follow-up occurring within 60 days of the initial screen	Number of positive depression screens using a standardized depression screening tool from continuously enrolled ¹ members which were completed on or after January 1 of measurement year through November 1 of the measurement year
Medicaid Advantage Plus plans only: Percentage of positive depression screens that were referred for a Behavioral Health carved-in benefit within one week of the positive screening	Number of positive depression screens completed by continuously enrolled ¹ members on or after January 1 through December 23 of the measurement year and were referred for the Behavioral Health carved-in benefit within one week (seven days) of positive screening result	Number of positive depression screens from continuously enrolled ¹ members which were completed on or after January 1 of the measurement year through seven days prior to December 23

¹ Continuous enrollment is defined as enrollment with the current plan for six months or more.

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 began at the start of 2024, IPRO reviewed elements 1-8 as part of the validation activity for measurement year 2024.

At the conclusion of interim and final reporting periods of the performance improvement project, a determination is made as to the overall credibility of the results, 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 were 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 2024 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 and interim), 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

At the end of the Interim reporting period 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 10** for Medicaid Advantage Plus, **Table 11** for Partial Capitation Plans, and **Table 12** for Program of All-Inclusive Care for the Elderly Plans. Performance indicator rates are in **Table 13**, **Table 14**, and **Table 15**.

UnitedHealthcare's Medicaid Advantage Plus plan does not have information reported in the performance improvement project summaries and results sections as it did not have any enrolled members in 2024, and therefore did not meet the minimum membership criteria for reporting. Additionally, ArchCare, Elderwood Health Plan, EverCare, Kalos Health Inc., Prime Health, and Senior Network Health Partially Capitated plans do not have information reported in the performance improvement project summaries and results sections because each plan underwent an acquisition during 2024 which is the first year of the two-year performance improvement project cycle. As a result, these plans did not satisfy the continuity and data stability requirements necessary for inclusion under the Centers for Medicare & Medicaid Services-aligned reporting specifications.

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 10: Medicaid Advantage Plus Performance Improvement Project Validation Findings, Measurement Year 2024

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 ²
Anthem HealthPlus Dual Plus (HMO D-SNP)	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Centers Plan for Healthy Living	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Elderplan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
ElderServe MAP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Hamaspik	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Healthfirst CompleteCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
MetroPlus Ultra Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Senior Whole Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
VillageCareMAX Medicare Total Advantage	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
VNS Health Total	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Wellcare Fidelis Dual Plus (HMO D-SNP)	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable

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** and **Achieved Sustained Improvement** are included in the validation review the year that the performance improvement project concludes.

Table 11: Partial Capitation Performance Improvement Project Validation Findings, Measurement Year 2024

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 ²
Aetna Better Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Anthem Blue Cross and Blue Shield HP MLTC	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Centers Plan for Healthy Living	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Fidelis Care at Home	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Hamaspik Choice	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
HomeFirst	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
iCircle	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
MetroPlus Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Nascentia Health Options	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
RiverSpring at Home	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Senior Health Partners	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Senior Whole Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
VillageCareMAX	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
VNS Health Choice	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable

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** and **Achieved Sustained Improvement** are included in the validation review the year that the performance improvement project concludes.

Table 12: Program of All-Inclusive Care for the Elderly Performance Improvement Project Validation Findings, Measurement Year 2024

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 ²
ArchCare Senior Life	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Catholic Health-LIFE	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
CenterLight	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Complete Senior Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Eddy SeniorCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
ElderONE	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Fallon Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
PACE CNY	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Total Senior Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable

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** and **Achieved Sustained Improvement** are included in the validation review the year that the performance improvement project concludes.

Table 13: Medicaid Advantage Plus Performance Improvement Project Decreasing Rates of Depression, Measurement Year 2024

Medicaid Advantage Plus Performance Improvement Project Indicator Rates					
Medicaid Advantage Plus	Percentage of members reporting no depressive feelings	Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Percentage of positive depression screens that have a documented intervention	Percentage of positive depression screens with follow-up	Percentage of positive depression screens with a referral for Behavioral Health carved-in benefit
Anthem HealthPlus Dual Plus (HMO D-SNP)	91.67%	28.57%	50.00%	0.00%	50.00%
Centers Plan for Healthy Living	60.57%	33.25%	100.00%	99.07%	100.00%
Elderplan	59.99%	57.66%	73.53%	73.53%	17.65%
ElderServe MAP	64.42%	9.38%	66.67%	66.67%	N/A*
Hamaspik	65.07%	27.72%	61.63%	91.57%	29.07%
Healthfirst CompleteCare	86.10%	11.82%	92.68%	99.77%	74.79%
MetroPlus Ultra Care	92.50%	100.00%	100.00%	100.00%	66.67%
Senior Whole Health	89.41%	11.10%	0.00%	0.00%	0.00%
VillageCareMAX Medicare Total Advantage	80.25%	7.33%	96.00%	92.00%	73.91%
VNS Health Total	88.30%	0.00%	75.00%	8.33%	16.67%
Wellcare Fidelis Dual Plus (HMO D-SNP)	74.72%	9.85%	100.00%	34.09%	52.17%

*No members were eligible or required an external Behavioral Health benefit referral

Table 14: Partial Capitation Performance Improvement Project Decreasing Rates of Depression, Measurement Year 2024

Partial Capitation Performance Improvement Project Indicator Rates				
Partial Capitation Plan	Percentage of members reporting no depressive feelings	Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Percentage of positive depression screens that have a documented intervention	Percentage of positive depression screens with follow-up
Aetna Better Health	93.22%	15.13%	57.14%	76.19%
Anthem Blue Cross and Blue Shield HP MLTC	78.00%	8.82%	8.26%	5.93%
Centers Plan for Healthy Living	56.30%	27.18%	99.73%	96.89%
Fidelis Care at Home	74.72%	9.85%	100.00%	34.09%
Hamaspik Choice	67.48%	17.13%	74.70%	90.38%
HomeFirst	53.02%	58.10%	79.08%	79.08%
iCircle	58.28%	30.67%	72.60%	56.14%
MetroPlus Health	91.55%	97.68%	100.00%	98.81%
Nascentia Health Options	82.71%	14.59%	54.22%	7.23%
RiverSpring at Home	61.54%	19.12%	68.24%	67.59%
Senior Health Partners	83.57%	12.85%	93.30%	99.83%
Senior Whole Health	75.25%	5.49%	40.31%	18.13%
VillageCareMAX	76.26%	5.69%	93.29%	81.08%
VNS Health Choice	84.90%	2.01%	59.09%	19.70%

Table 15: Program of All-Inclusive Care for the Elderly Performance Improvement Project Decreasing Rates of Depression, Measurement Year 2024

Program of All-Inclusive for the Elderly Performance Improvement Project Indicator Rates				
Program of All-Inclusive Care for the Elderly Plan	Percentage of members reporting no depressive feelings	Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Percentage of positive depression screens that have a documented intervention	Percentage of positive depression screens with follow-up
ArchCare Senior Life	95.66%	33.33%	40.00%	20.00%
Catholic Health-LIFE	89.82%	47.06%	100.00%	100.00%
CenterLight	88.38%	28.92%	97.57%	98.28%
Complete Senior Care	64.71%	27.78%	80.00%	40.00%
Eddy SeniorCare	79.09%	83.07%	100.00%	78.95%
ElderONE	65.55%	34.45%	100.00%	100.00%
Fallon Health	45.06%	78.87%	100.00%	41.07%
PACE CNY	88.10%	88.89%	100.00%	100.00%
Total Senior Care	60.91%	48.84%	100.00%	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 Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy

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 measures 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.

2024 Performance Measure Validation Summary

Validation Process

- Are reporting practices and performance measure specifications compliant?
- Is each performance measure accurate? Is it complete?

Validation Results

- IPRO validated seven performance measures that were calculated by the Department of Health.

Performance Measure Rates

- Of the **Medicaid Advantage Plus** rates included in this report, **35% performed statistically significantly better** than statewide Managed Long-Term Care performance; **18% performed statistically significantly worse** than statewide Managed Long-Term Care performance; and **47% did not differ in performance** from statewide Managed Long-Term Care performance.
- Of the **Partial Capitation** rates included in this report, **49% performed statistically significantly better** than statewide Managed Long-Term Care performance; **38% performed statistically significantly worse** than statewide Managed Long-Term Care performance; and **13% 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, **21% performed statistically significantly better** than statewide Managed Long-Term Care performance; **38% performed statistically significantly worse** than statewide Managed Long-Term Care performance; and **41% 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 Section 438.358 Activities related to external quality review (2)(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 2024.

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 annual (or, in the case of PACE members, every six months), 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.

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 2024, 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 16**.

Table 16: 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 2024 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 1.18.x* (October 2024), a print version of *the Uniform*

Assessment System for New York Community Health Assessment (September 2024), and SAS® source code used by the Department of Health to calculate performance rates for the measures in **Table 16**.

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 1.18.x* (October 2024) 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* (September 2024) 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 2024 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 17, **Table 18**, and **Table 19** 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. Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

UnitedHealthcare’s Medicaid Advantage Plus plan was excluded from the performance measure results. Although United Healthcare’s Medicaid Advantage Plus plan remained active during the 2024 reporting year, it did not have any enrolled members, and therefore did not meet the minimum membership criteria for reporting. Additionally, ArchCare, Elderwood Health Plan, Evercare, Prime Health Choice, and Senior Network Health plans were excluded from the Partially Capitated results because each plan underwent an acquisition during the first half of the 2024 reporting year. As a result, these plans did not satisfy the continuity and data stability requirements necessary for inclusion under Centers for Medicare & Medicaid Services-aligned reporting specifications.

Table 17: Medicaid Advantage Plus Performance Measure Results

Medicaid Advantage Plus Quality Measures and Rates							
Medicaid Advantage Plus ¹	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 ²	71%	96%	98%	99%	78%	83%	80%
Anthem HealthPlus Dual Plus (HMO D-SNP)	88%	99%	99%	100%	83%	90%	79%
Centers Plan for Healthy Living	45%	85%	99%	99%	75%	89%	57%
Elderplan	41%	99%	100%	100%	76%	85%	90%
ElderServe MAP	50%	99%	91%	97%	78%	78%	78%
Hamaspik	74%	100%	99%	100%	75%	83%	62%
Healthfirst CompleteCare	87%	99%	97%	99%	76%	78%	88%
MetroPlus Ultra Care	85%	95%	91%	95%	71%	83%	82%
Senior Whole Health	84%	100%	99%	100%	88%	90%	94%
VillageCareMAX Medicare Total Advantage	86%	99%	99%	99%	81%	83%	85%
VNS Health Total	92%	99%	99%	99%	88%	96%	93%
Wellcare Fidelis Dual Plus (HMO D-SNP)	70%	95%	97%	99%	69%	78%	80%

¹ United Healthcare’s Medicaid Advantage Plus plan is not included in the performance measure results. Though United Healthcare’s Medicaid Advantage Plus plan was open during the 2024 reporting year, there were no members enrolled.

² 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Table 18: Partial Capitation Performance Measure Results

Partial Capitation Quality Measures and Rates							
Partial Capitation ¹	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 ²	71%	96%	98%	99%	78%	83%	80%
Aetna Better Health	89%	98%	99%	99%	80%	81%	83%
Anthem Blue Cross and Blue Shield HP MLTC	82%	100%	99%	100%	84%	85%	85%
Centers Plan for Healthy Living	45%	85%	99%	100%	78%	88%	59%
Fidelis Care at Home	70%	94%	96%	99%	67%	75%	79%
Hamaspik Choice	74%	99%	99%	100%	81%	91%	67%
HomeFirst	47%	99%	99%	100%	76%	82%	90%
Kalos Health Inc.	59%	100%	100%	99%	70%	77%	72%
iCircle	44%	78%	82%	87%	67%	73%	50%
MetroPlus Health	91%	97%	94%	97%	76%	78%	86%
Nascentia Health Options	55%	98%	97%	98%	71%	79%	79%
RiverSpring at Home	46%	99%	90%	98%	65%	61%	68%
Senior Health Partners	87%	99%	98%	99%	71%	72%	82%
Senior Whole Health	85%	99%	99%	100%	84%	88%	89%
VillageCareMAX	83%	99%	99%	99%	78%	82%	85%
VNS Health Choice	89%	99%	98%	99%	82%	92%	90%

¹ The following Partially Capitated plans were not included in the performance measure results due to being acquired during the first half of the 2024 reporting year: ArchCare, Elderwood, Evercare, Prime Health Choice, and Senior Network Health.

² 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Table 19: 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	71%	96%	98%	99%	78%	83%	80%
ArchCare Senior Life	85%	98%	99%	99%	85%	80%	77%
Catholic Health-LIFE	45%	93%	88%	95%	90%	76%	91%
CenterLight	98%	99%	99%	100%	93%	84%	95%
Complete Senior Care	24%	93%	87%	56%	86%	88%	91%
Eddy SeniorCare	48%	95%	83%	87%	90%	92%	68%
ElderONE	73%	97%	97%	92%	82%	89%	70%
Fallon Health	51%	96%	89%	96%	66%	54%	75%
PACE CNY	47%	96%	94%	97%	83%	88%	75%
Total Senior Care	43%	87%	80%	65%	86%	88%	80%

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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 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 Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy

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 Survey¹⁰. 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.

¹⁰ 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 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* be performed. 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.

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 and focused surveys conducted in 2022 through 2024 for the Medicaid Advantage Plus and Partial Capitation managed care plans by the Department of Health are presented in this report. The results of the focused surveys conducted in 2022 through 2024 for the Program of All-Inclusive Care for the Elderly managed care plans by the Centers for Medicare & Medicaid Services are also presented in this report. The results of the compliance activities conducted in 2022 and 2023 are included in this report for a three year look back.

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 Services¹¹. 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.

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,

¹¹ 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.

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 crosswalked 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 2022, 2023 and 2024, 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.

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 Managed Long Term Care 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

To evaluate managed care plan compliance with federal and state standards, IPRO consulted the Department of Health-produced *Operational Deficiencies by Plan/Category Report*, *Operational Plan Deficiencies Report*, and *Operational and Focused Survey Schedule Summary*. The *Operational Deficiencies by Plan/Category Report* included a summary of noncompliance by review area for each managed care plan, while the *Operational Plan Deficiencies Report* included detailed information on the areas of noncompliance for each managed care plan. Both reports reflected the date when the results were issued by the Department of Health to the managed care plan, the Plan of Correction submission date, and the Plan of Correction approval date. The *Operational and Focused Survey Schedule Summary* included identification of when each survey review occurred.

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 *Appeals and Fair Hearing Survey Methodology* (results issued in 2022), *Member Services Survey Methodology* (results issued in 2022), *Complaint Investigation Survey Methodology* (results issued in 2022), *Provider Network Data System Survey Methodology for Partial Capitation and Program for All-Inclusive Care for the Elderly Plans* (results issued in 2023), *Provider Network Data System Survey Methodology for Medicaid Advantage Plus Plans* (results issued in 2024), *Site Evaluation Survey Methodology* (results issued in 2024), *Self Disclosure Survey Methodology* (results issued in 2024), *Management Services Agreement Survey Methodology* (results issued in 2024), *Social Day Care Reduction Survey Methodology* (results issued in 2023), and *Person Centered Service Plan Survey Methodology* (results issued in 2024) documents 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 (2023)* 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.

Comparative Results

The compliance survey activity schedule, and when the survey review occurred for measurement years 2022-2024 can be found in **Table 20**, **Table 21**, and **Table 22**. When available, Managed Long-Term Care plan results for the Operational and Focused Survey activities are presented by federal Medicaid standards in **Table 23**, **Table 24**, and **Table 25**. 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 20 reports when each Medicaid Advantage Plus survey review occurred for the results issued in **Table 23**. **Table 21** reports when each Partial Capitation survey review occurred for the results issued in **Table 24**. **Table 22** reports when each Program of All-Inclusive Care for the Elderly survey review occurred for the results issued in **Table 25**.

Table 20: Medicaid Advantage Plus Managed Care Plan Survey Schedule, Measurement Year, 2022-2024

Medicaid Advantage Plus Plan	Compliance Survey Activity	Survey Review Begin Date	Results Issued
AgeWell ¹	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
Anthem HealthPlus Dual Plus (HMO D-SNP)	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
Centers Plan for Healthy Living	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
ElderServe MAP	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
Elderplan	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
	Focused Survey ⁴	May 2024	2024
Hamaspik	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
	Focused Survey ⁵	June 2024	2024
Healthfirst CompleteCare	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
MetroPlus Ultra Care	Focused Survey ³	July 2023	2024
Senior Whole Health	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
VillageCareMAX Medicare Total Advantage	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
VNS Health Total	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024
	Focused Survey ⁶	May 2023	2024
Wellcare Fidelis Dual Plus (HMO D-SNP)	Focused Survey ²	August 2021	2022
	Focused Survey ³	July 2023	2024

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

² Appeals and Fair Hearing Focused Survey.

³ Provider Network Delivery System Focused Survey.

⁴ Site Evaluation Focused Survey.

⁵ Management Services Agreement Focused Survey.

⁶ Self Disclosure Focused Survey.

Table 21: Partial Capitation Managed Care Plan Survey Schedule, Measurement Year, 2022-2024

Partial Capitation Plan	Compliance Survey Activity	Survey Review Begin Date	Results Issued
Aetna Better Health	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Anthem Blue Cross and Blue Shield HP MLTC	Focused Survey ¹	August 2021	2022
	Focused Survey ³	February 2022	2022
	Focused Survey ⁴	February 2022	2022
	Focused Survey ²	July 2023	2023
	Comprehensive	September 2023	2024
Archcare⁵	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Centers Plan for Healthy Living	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Elderwood Health Plan⁶	Focused Survey ¹	August 2021	2022
	Comprehensive	March 2022	2023
	Focused Survey ²	July 2023	2023
EverCare⁷	Focused Survey ¹	August 2021	2022
	Comprehensive	March 2022	2022
	Focused Survey ²	July 2023	2023
Extended MLTC⁸	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Fallon Health	Comprehensive	November 2021	2022
	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
	Focused Survey ⁹	March 2024	2024
Fidelis Care at Home	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Hamaspik Choice	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
	Comprehensive	September 2023	2024
	Focused Survey ¹⁰	July 2024	2024
HomeFirst	Focused Survey ¹	August 2021	2022

Partial Capitation Plan	Compliance Survey Activity	Survey Review Begin Date	Results Issued
	Comprehensive	March 2022	2023
	Focused Survey ²	July 2023	2023
	Focused Survey ¹¹	July 2023	2023
	Focused Survey ¹²	May 2024	2024
iCircle	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Kalos Health Inc.	Focused Survey ¹	August 2021	2022
	Comprehensive	November 2021	2022
	Focused Survey ²	July 2023	2023
MetroPlus Health	Focused Survey ¹	August 2021	2022
	Comprehensive	May 2023	2023
	Focused Survey ²	July 2023	2023
Montefiore ¹³	Focused Survey ¹	August 2021	2022
	Comprehensive	September 2022	2023
	Focused Survey ²	July 2023	2023
Nascentia Health Options	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Prime Health ¹⁴	Focused Survey ¹	August 2021	2022
	Comprehensive	September 2022	2023
	Focused Survey ²	July 2023	2023
RiverSpring at Home	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Senior Health Partners	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Senior Network Health ¹⁵	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
Senior Whole Health	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
VillageCareMAX	Focused Survey ¹	August 2021	2022
	Comprehensive	May 2023	2023
	Focused Survey ²	July 2023	2023
VNS Health Choice	Focused Survey ¹	August 2021	2022
	Focused Survey ²	July 2023	2023
	Focused Survey ¹⁶	July 2023	2024

¹ Appeals and Fair Hearing Focused Survey.

- ² Provider Network Delivery System Focused Survey.
- ³ Member Services Survey.
- ⁴ Complaint Investigation Survey.
- ⁵ Archcare was acquired by VillageCareMAX on 6/1/2024.
- ⁶ Elderwood Health Plan was acquired by VNS Health Choice on 5/1/2024.
- ⁷ EverCare was acquired by HomeFirst on 5/1/2024.
- ⁸ Extended MLTC was acquired by Hamaspik on 8/1/2023.
- ⁹ Management Services Agreement Focused Survey.
- ¹⁰ Person Centered Service Plan Focused Survey.
- ¹¹ Social Day Care Reduction Focused Survey
- ¹² Site Evaluation Focused Survey.
- ¹³ Montefiore was acquired by RiverSpring on 12/31/2023.
- ¹⁴ Prime Health was acquired by VNS Health Choice on 5/1/2024.
- ¹⁵ Senior Network Health was acquired by VNS Health Choice on 6/1/2024.
- ¹⁶ Self Disclosure Focused Survey.

Table 22: Program of All-Inclusive Care for the Elderly Managed Care Plan Survey Schedule, Measurement Year, 2022-2024

Program of All-Inclusive Care for the Elderly Plan	Compliance Survey Activity	Survey Review Begin Date	Results Issued
ArchCare Senior Life	Focused Survey ¹	July 2023	2023
	Focused Survey ²	August 2023	2023
Catholic Health-LIFE	Focused Survey ¹	July 2023	2023
CenterLight	Focused Survey ¹	July 2023	2023
Complete Senior Care	Focused Survey ¹	July 2023	2023
Eddy SeniorCare	Focused Survey ¹	July 2023	2023
ElderONE	Focused Survey ¹	July 2023	2023
Fallon Health	Focused Survey ¹	July 2023	2023
	Focused Survey ²	January 2023	2023
	Focused Survey ³	March 2024	2024
PACE CNY	Focused Survey ¹	July 2023	2023
Total Senior Care	Focused Survey ¹	July 2023	2023

- ¹ Provider Network Delivery System Focused Survey.
- ² Performance Improvement Project Focused Survey.
- ³ Management Services Agreement Focused Survey.

Table 23: 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	Focused Survey ²	2022										C				
	Open Period	2023														
	Focused Survey ³	2024				NC										
Anthem HealthPlus Dual Plus (HMO D-SNP)	Focused Survey ²	2022										C				
	Open Period	2023														
	Focused Survey ³	2024				NC										
Centers Plan for Healthy Living	Focused Survey ²	2022										C				
	Open Period	2023														
	Focused Survey ³	2024				C										
ElderServe MAP	Focused Survey ²	2022										C				
	Open Period	2023														
	Focused Survey ³	2024				C										
Elderplan	Focused Survey ²	2022										C				
	Open Period	2023														
	Focused Survey ³	2024				NC										

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
	Focused Survey ⁴	2024				NC										
Hamaspik	Focused Survey ²	2022										C				
	Focused Survey ³	2024				NC										
	Focused Survey ⁵	2024											NC			
Healthfirst CompleteCare	Focused Survey ²	2022										NC				
	Open Period	2023														
	Focused Survey ³	2024				NC	C									
MetroPlus Ultra Care	Open Period	2022														
	Open Period	2023														
	Focused Survey ³	2024				C										
Senior Whole Health	Focused Survey ²	2022										NC				
	Open Period	2023														
	Focused Survey ³	2024				NC	NC									
VillageCareMAX Medicare Total Advantage	Focused Survey ²	2022										C				
	Open Period	2023														

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
	Focused Survey ³	2024				NC										
VNS Health Total	Focused Survey ²	2022										NC				
	Open Period	2023														
	Focused Survey ³	2024				NC										
	Focused Survey ⁶	2024		NC					NC							
Wellcare Fidelis Dual Plus (HMO D-SNP)	Focused Survey ²	2022										C				
	Open Period	2023														
	Focused Survey ³	2024				NC										

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

² Appeals and Fair Hearing Focused Survey.

³ Provider Network Delivery System Focused Survey.

⁴ Site Evaluation Focused Survey.

⁵ Management Services Agreement Focused Survey.

⁶ Self Disclosure Focused Survey.

Table 24: 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 Better Health	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
Anthem Blue Cross and Blue Shield HP MLTC	Focused Survey ¹	2022										C				
	Focused Survey ³	2022														
	Focused Survey ⁴	2022							NC							
	Focused Survey ²	2023				C										
	Comprehensive	2024	C	NC	C	C	C	C	C	C	C	NC	C	C	C	C
Archcare ⁵	Focused Survey ¹	2022										C				
	Focused Survey ²	2023				NC										
Centers Plan for Healthy Living	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
Elderwood Health Plan ⁶	Focused Survey ¹	2022										C				
	Comprehensive	2023	C	C	C	NC	C	NC	NC	C	C	C	C	C	NC	C
	Focused Survey ²	2023				NC										
EverCare ⁷	Comprehensive	2022	C	NC	C	C	C	NC	NC	C	C	C	C	C	NC	C
	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
Extended MLTC ⁸	Focused Survey ¹	2022										C				
	Focused Survey ²	2023				NC										
Fallon Health	Comprehensive	2022	C	C	C	NC	C	NC	NC	NC	C	C	C	C	NC	C
	Focused Survey ¹	2022										C				
	Focused Survey ²	2023				C										
	Focused Survey ⁹	2024											NC			
Fidelis Care at Home	Focused Survey ¹	2022										C				
	Focused Survey ²	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
	Not Yet Available	2024														
Hamaspik Choice	Focused Survey ¹	2022										C				
	Focused Survey ²	2023				NC										
	Comprehensive	2024	C	NC	C	NC	C	NC	NC	NC	C	NC	C	C	NC	C
	Focused Survey ¹⁰	2024						NC								
HomeFirst	Focused Survey ¹	2022										NC				
	Comprehensive	2023	C	C	C	C	C	NC	NC	C	C	C	C	C	C	C
	Focused Survey ²	2023				NC										
	Focused Survey ¹¹	2023		NC					NC							
	Focused Survey ¹²	2024				NC										
iCircle	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
Kalos Health Inc.	Comprehensive	2022	C	C	C	NC	C	NC	NC	NC	C	C	C	C	NC	C
	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
MetroPlus Health	Focused Survey ¹	2022										NC				
	Comprehensive	2023	NC	C	C	C	C	NC	C	C	C	NC	C	C	NC	C
	Focused Survey ²	2023				C										
	Not Yet Available	2024														
Montefiore ¹³	Focused Survey ¹	2022										C				
	Comprehensive	2023	C	C	C	C	C	NC	C	NC	C	C	NC	C	NC	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
	Focused Survey ²	2023				C										
Nascentia Health Options	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
Prime Health ¹⁴	Focused Survey ¹	2022										C				
	Comprehensive	2023	C	C	C	NC	C	NC	NC	NC	C	NC	NC	C	C	C
	Focused Survey ²	2023				NC										
RiverSpring at Home	Focused Survey ¹	2022										C				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
Senior Health Partners	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
Senior Network Health ¹⁵	Focused Survey ¹	2022										C				
	Focused Survey ²	2023				NC										
Senior Whole Health	Focused Survey ¹	2022										NC				
	Focused Survey ²	2023				NC										
	Not Yet Available	2024														
VillageCare MAX	Focused Survey ¹	2022										NC				
	Comprehensive	2023	C	C	C	C	C	NC	C	C	C	NC	C	C	C	C
	Focused Survey ²	2023				C										
	Not Yet Available	2024														
	Focused Survey ¹	2022										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
VNS Health Choice	Focused Survey ²	2023				NC										
	Focused Survey ¹⁶	2024		NC					NC							

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Member Services Survey. Areas surveyed were outside of Title 42 Code of Federal Regulations 438 requirements.

⁴ Complaint Investigation Survey.

⁵ Archcare was acquired by VillageCareMAX on 6/1/2024.

⁶ Elderwood Health Plan was acquired by VNS Health Choice on 5/1/2024.

⁷ EverCare was acquired by HomeFirst on 5/1/2024.

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

⁹ Management Services Agreement Focused Survey.

¹⁰ Person Centered Service Plan Focused Survey.

¹¹ Social Day Care Reduction Focused Survey

¹² Site Evaluation Focused Survey.

¹³ Montefiore was acquired by RiverSpring at Home on 12/31/2023.

¹⁴ Prime Health was acquired by VNS Health Choice on 5/1/2024.

¹⁵ Senior Network Health was acquired by VNS Health Choice on 6/1/2024.

¹⁶ Self Disclosure Focused Survey.

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 25: 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 Senior Life	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	Focused Survey ³	2023														NC
	No Activity ¹	2024														
Catholic Health-LIFE	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	No Activity ¹	2024														
CenterLight	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	No Activity ¹	2024														
Complete Senior Care	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	No Activity ¹	2024														
Eddy SeniorCare	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	No Activity ¹	2024														
ElderONE	No Activity ¹	2022														
	Focused Survey ²	2023				NC										
	No Activity ¹	2024														
Fallon Health	No Activity ¹	2022														
	Focused Survey ²	2023				C										
	Focused Survey ³	2023														NC
	Focused Survey ⁴	2024											NC			
PACE CNY	No Activity ¹	2022														
	Focused Survey ²	2023				C										
	No Activity ¹	2024														

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	2022														
	Focused Survey ²	2023				NC										
	No Activity ¹	2024														

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.

⁴ Management Services Agreement 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 Standards
Required	External Quality Review Activity 4. Validation of Network Adequacy

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 2024, all Managed Long-Term Care Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care Plans were reviewed to ensure their networks met the standards.

2024 Network Adequacy Summary

Validation Process

- Do managed care plan provider networks follow the applicable state and/or federal 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 applicable federal standards for network adequacy.
- 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 Section 438.356 State contract options for 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 2024.

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 Advantage Plus Model Contract*, the *Medicaid Managed Long-Term Care Partial Capitation 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 Medicaid Advantage Plus, Partial Capitation, 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 26, Table 27, and Table 28 display the Department of Health’s travel time standards, and **Table 29, Table 30, and Table 31** display the Department of Health’s service delivery network standards. The 2022-2026 Medicaid Advantage Plus Model Contract section 15.5 Travel Time Standards, 2022-2026 Partial Capitation Model Contract section D Network Requirements of Covered Services, and 42 Code of Federal Regulations Part 460 (e) PACE Center Operation displayed in **Table 29, Table 30, and Table 31** were applicable to Managed Long-Term Care Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly Plans except where noted.

Table 26: 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 27: 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 28: 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 29: 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 County ¹
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

New York Medicaid Advantage Plus Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County¹
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
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

New York Medicaid Advantage Plus Service Delivery Network Standards

Service Type	Service Specification	Service Delivery Network Standard Per County 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 ²	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
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.

² As of March 1st, 2024, non-emergent medical transportation was carved out of Medicaid Advantage Plus and Partial Capitation Managed Long-Term Care Plans.

Table 30: 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
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 ²	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 County 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
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.

² As of March 1st, 2024, non-emergent medical transportation was carved out of Medicaid Advantage Plus and Partial Capitation Managed Long-Term Care Plans.

Table 31: 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 County ¹
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

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

Service Type	Service Specification	Service Delivery Network Standard Per County¹
General Surgery	Provider	Minimum of two (2) per county statewide 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

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
Podiatry	Provider	Minimum of two (2) per county statewide 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.

Technical Methods of 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 32**.

Table 32: 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 5 business days of receipt.

Description of Data Obtained

For the 2024 external quality review period, the Department of Health provided IPRO with copies of the *Medicaid Advantage Plus Model Contract*, *Medicaid Managed Long-Term Care Partial Capitation 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 2024 submissions (submitted on a quarterly basis) to the Provider Network Data System. The standards put in place by the Department of Health are in addition to the federal requirements. All Medicaid Advantage Plus Plans, Managed Long-Term Care Partial Capitation Plans, and Program of All-Inclusive Care for the Elderly Plans met the federal requirements for Network Adequacy.

The *Medicaid Advantage Plus Model Contract*, the *Medicaid Managed Long-Term Care Partial Capitation Model Contract*, and the *Program of All-Inclusive Care for the Elderly Model Contract* include 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. These documents also specify 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 33**, **Table 34**, and **Table 35**. 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 33: Medicaid Advantage Plus Evaluation of Network Adequacy, 2024

Managed Care Plan	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Medicaid Advantage Plus
Anthem HealthPlus Dual Plus (HMO D-SNP)	Pass	Met
Centers Plan for Healthy Living	Pass	Met
Elderplan	Pass	Met
ElderServe MAP	Pass	Met
Hamaspik	Pass	Met
Healthfirst CompleteCare	Pass	Met
MetroPlus Ultra Care	Pass	Met

Managed Care Plan	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Medicaid Advantage Plus
Senior Whole Health	Pass	Met
United Healthcare ¹	Pass	Met
VillageCareMAX Medicare Total Advantage	Pass	Met
VNS Health Total	Pass	Met
Wellcare Fidelis Dual Plus (HMO D-SNP)	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.

¹United Healthcare was established in 2024 but had no enrollment until May of 2025.

Table 34: Partial Capitation Evaluation of Network Adequacy, 2024

Managed Care Plan ¹	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Partial Capitation
Aetna Better Health	Pass	Met
Anthem Blue Cross and Blue Shield HP MLTC	Pass	Met
Archcare ¹	Pass	Met
Centers Plan for Healthy Living	Pass	Met
Elderwood Health Plan ²	Pass	Met
EverCare ³	Pass	Met
Fidelis Care at Home	Pass	Met
Hamaspik Choice	Pass	Met
HomeFirst	Pass	Met
iCircle	Pass	Met
Kalos Health Inc. ⁴	Pass	Met
MetroPlus Health	Pass	Met
Nascentia Health Options	Pass	Met
Prime Health ⁵	Pass	Met
RiverSpring at Home	Pass	Met
Senior Health Partners	Pass	Met
Senior Network Health ⁶	Pass	Met
Senior Whole Health	Pass	Met
VillageCareMAX	Pass	Met
VNS Health Choice	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 Archcare was acquired by VillageCareMAX effective 6/1/2024.

² Elderwood Health Plan was acquired by VNS Health Choice effective 5/1/2024.

³ EverCare was acquired by HomeFirst effective 5/1/2024.

⁴ Kalos Health, Inc. was acquired by VNS Health Choice effective 12/1/2024.

⁵ Prime Health was acquired by VNS Health Choice effective 5/1/2024.

⁶ Senior Network Health was acquired by VNS Health Choice effective 6/1/2024.

Table 35: Program of All-Inclusive Care for the Elderly Evaluation of Network Adequacy, 2024

Managed Care Plan	Validation Result (Pass/Fail)	Evaluation of Network Adequacy Program of All-Inclusive Care for the Elderly
ArchCare Senior Life	Pass	Met
Catholic Health-LIFE	Pass	Met
CenterLight	Pass	Met
Complete Senior Care	Pass	Met
Eddy SeniorCare	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.

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 2023 external quality review recommendations, as well as plan-level results from the external quality review activities. Specifically, IPRO considered the following elements during the 2024 external quality review:

- Managed Long-Term Care Plan Follow-up on 2023 External Quality Review Recommendations
- External Quality Review Mandatory Activity 1. Performance Improvement Projects, 2024
- External Quality Review Mandatory Activity 2. Performance Measures, 2024
- External Quality Review Mandatory Activity 3. Compliance with Medicaid Program Standards, 2022-2024
- External Quality Review Mandatory Activity 4. Network Adequacy, 2024

Assessment of Managed Care Plan Follow-up on the 2023 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 *2023 External Quality Review Technical Report*. Managed Long-Term Care plan responses are reported in this section of the report.

Table 36 displays the assessment categories used by IPRO to describe Managed Long-Term Care progress towards addressing the 2023 external quality review recommendations.

Table 36: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions	
Addressed	The managed care plan’s response addressed the recommendation(s) and provided an actionable quality improvement plan.
Partially Addressed	The managed care plan’s quality improvement response addressed and provided an actionable quality improvement plan for some but not all of the recommendation(s).
Remains an Opportunity for Improvement	The managed care plan’s quality improvement response did not address the recommendation(s).

Performance Improvement Project Summary and Results, 2024

This section displays a comprehensive summary of the Managed Long-Term Care plans' performance improvement projects that were in place in 2024. 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. The maintenance (within one percentage point) of a performance indicator from measurement year 2023 to 2024 was also considered a strength. Four performance indicators were evaluated for strengths or opportunities for improvement: the percentage of members reporting no depressive feelings, the percentage of members reporting depressive feelings and had a follow-up positive depression screen, the percentage of positive depression screens that have a documented intervention (within two weeks), and the percentage of positive depression screens with follow-up (within 60 days). An additional performance indicator was evaluated for Medicaid Advantage Plus plans only which tracked the percentage of positive depression screens with a referral for behavioral health carved-in benefit (within one week).

Performance Measures Results, 2024

This section displays the Managed Long-Term Care plan performance rates for measurement years 2022 through 2024, as well as the program average rates for measurement year 2024. 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, 2022-2024

This section displays Managed Long-Term Care plan results for the 2022 through 2024 compliance activities conducted within the three-year period. A Managed Long-Term Care plan meeting compliance with federal Medicaid standards in 2024 was considered a strength during this evaluation, while noncompliance with a required standard was considered an opportunity for improvement.

Network Adequacy Results, 2024

This section displays managed care plan results for the 2024 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.

Strengths, Opportunities for Improvement, and Recommendations, 2024

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' 2024 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).

AgeWell

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

AgeWell Medicaid Advantage Plus announced a withdrawal effective 01/01/2024.

Performance Improvement Project Summaries and Results

AgeWell Medicaid Advantage Plus announced a withdrawal effective 01/01/2024.

Performance Measure Results

AgeWell Medicaid Advantage Plus announced a withdrawal effective 01/01/2024.

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

Table 37: AgeWell’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Table 38: AgeWell’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
AgeWell failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206

Network Adequacy Results

AgeWell Medicaid Advantage Plus announced a withdrawal effective 01/01/2024.

Strengths, Opportunities for Improvement, and Recommendations

AgeWell Medicaid Advantage Plus announced a withdrawal effective 01/01/2024.

Anthem HealthPlus Dual Plus (HMO D-SNP)

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, Anthem HealthPlus Dual Plus (HMO D-SNP) operated under the name Empire BCBS HealthPlus.

Table 39: Anthem HealthPlus Dual Plus (HMO D-SNP)’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Anthem HealthPlus Dual Plus’s (HMO D-SNP) Response	IPRO’S Assessment of Anthem HealthPlus Dual Plus’s (HMO D-SNP) Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Anthem HealthPlus Dual Plus (HMO D-SNP) 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>Anthem HealthPlus Dual Plus (HMO D-SNP) continues to monitor these performance indicators and has developed and implemented new workflows to engage with the regional social care network lead entities who are responsible for screening referred Anthem HealthPlus Dual Plus (HMO D-SNP) members and providing navigation support to health-related social needs services within their region based on the member's needs. Anthem HealthPlus Dual Plus (HMO D-SNP) will track metrics related to health-related social needs screening, referrals, and utilization of community resources and analyze data to identify trends and areas for improvement.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Anthem HealthPlus Dual Plus (HMO D-SNP) 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</p>	<p>Anthem HealthPlus Dual Plus (HMO D-SNP) continuously uses data from the annual Managed Long-Term Care report to ensure our quality assurance/performance improvement program addresses all quality performance domains. By analyzing Anthem HealthPlus Dual Plus (HMO D-SNP) specific and statewide results, we determine whether our performance is above,</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Anthem HealthPlus Dual Plus's (HMO D-SNP) Response	IPRO'S Assessment of Anthem HealthPlus Dual Plus's (HMO D-SNP) Response
suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Anthem HealthPlus Dual Plus (HMO D-SNP) should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	equal to, or below the statewide average. This analysis forms the basis for data-driven improvement initiatives to enhance areas of care where rates fall below the mean, and guide efforts to elevate the Anthem HealthPlus Dual Plus's (HMO D-SNP) overall performance in the delivery of top-quality care.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Anthem HealthPlus Dual Plus (HMO D-SNP) 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.	To ensure readiness for the Department of Health's compliance review, Anthem HealthPlus Dual Plus (HMO D-SNP) conducts thorough internal assessments to proactively identify and address any potential issues. Updates and findings from these activities are consistently shared with the quality management committee, maintaining transparency and accountability.	Addressed.
Network Adequacy		
It is recommended Anthem HealthPlus Dual Plus (HMO D-SNP) 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.	Anthem HealthPlus Dual Plus (HMO D-SNP) has an established, robust network and will continue to enhance it to ensure all standards are met and members have access to care.	Partially Addressed.
Quality-of-Care Survey		
Despite its small sample size for the member satisfaction survey, Anthem HealthPlus Dual Plus (HMO D-SNP) should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Anthem HealthPlus Dual Plus (HMO D-SNP) actively utilizes data from internal member satisfaction survey to assess how our members rate their satisfaction with providers and services. By evaluating Anthem HealthPlus Dual Plus's (HMO D-SNP) performance, we develop data-driven initiatives to enhance member satisfaction, focusing on	Addressed.

2023 External Quality Review Recommendation	Anthem HealthPlus Dual Plus's (HMO D-SNP) Response	IPRO'S Assessment of Anthem HealthPlus Dual Plus's (HMO D-SNP) Response
	improving adverse experiences related to quality, timeliness, and access to care with the goal of continuously improving and ultimately delivering top-quality services to our members.	

Performance Improvement Project Summaries and Results

Table 40: Anthem HealthPlus Dual Plus (HMO D-SNP)'s Performance Improvement Project Summary, 2024

Anthem HealthPlus Dual Plus's (HMO D-SNP) Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of the final reporting year, Anthem HealthPlus Dual Plus (HMO D-SNP) aims to improve the rate of members reporting no depressive feelings on the Community Health Assessment from the baseline rate of 89.77% to 92.00%. ▪ By the end of the final reporting year, Anthem HealthPlus Dual Plus (HMO D-SNP) aims to increase the proportion of documented interventions for members screening positive (dcores of five or more on the Patient Health Questionnaire-9 Screening Tool) from an unknown baseline to 69.50%. ▪ By the end of the final reporting year, Anthem HealthPlus Dual Plus (HMO D-SNP) aims to increase the percentage of follow ups after a positive depression screening from an unknown baseline to 60.00%. ▪ By the end of the final reporting year, Anthem HealthPlus Dual Plus (HMO D-SNP) aims to increase the proportion of members referred to behavioral health team within two weeks of a positive depression screening from an unknown baseline to 25.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Assessed care managers' knowledge of depression screening and follow-up procedures. ▪ Conducted a staff training aimed to overcome knowledge gaps and how to enhance members willingness to discuss their mood and foster trust in mental health providers. ▪ Implemented the Patient Health Questionnaire-9 as the screening tool for all members identified as reporting depressive feelings on the Uniform Assessment System Community Health Assessment. ▪ Created and implemented a standard workflow to ensure that members who score five or more on the Patient Health Questionnaire-9 have appropriate follow up.

Table 41: Anthem HealthPlus Dual Plus (HMO D-SNP)'s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	89.77%	91.67%	92.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	28.57%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	Not Available	50.00%	69.50%
Percentage of positive depression screens with follow-up	Not Available	0.00%	60.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	Not Available	50.00%	25.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 42: Anthem HealthPlus Dual Plus (HMO D-SNP)'s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	93%	89%	88%	71%
No Severe Daily Pain	100%	100%	99%	96%
Pain Controlled	100%	100%	99%	98%
Not Lonely and Distressed	100%	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	70%	82%	83%	78%
Pneumococcal Vaccination	71%	87%	90%	83%
COVID-19 Vaccination	Not Available	81%	79%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 43: Anthem HealthPlus Dual Plus (HMO D-SNP)’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Table 44: Anthem HealthPlus Dual Plus (HMO D-SNP)’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Anthem HealthPlus Dual Plus (HMO D-SNP) failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206

Network Adequacy Results

Table 45: Anthem HealthPlus Dual Plus (HMO D-SNP)'s Network Gaps, 2024

Anthem HealthPlus Dual Plus (HMO D-SNP) Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	3	3	3	1		1	1	1								
Assertive Community Treatment	1							1								
Assistive Technology Agency and Adaptive Technology		5				2										
CORE Community Psychiatric Supports and Treatment		1	1	1		2	1	1								
CORE Family Support and Training				2			2									
CORE Peer Support						1	1	1								
CORE Psychosocial Rehabilitation							1									
Community Transitional Service		2				1										
Comprehensive Psychiatric Emergency Program								1								
Environmental Modifications		1				1										
Fiscal Intermediary	1	4	3													
General Dentistry		2	2													
Home and Community Support Services		6				3										
Inpatient Chemical Dependency (ASA Inpatient)					1											
Inpatient Mental Health	1							1								
Institutional Long Term Care	1	1				1										
Institutional Short Term Care					1	1		1								
Medically Managed Detox Services	1				1			3								
Medically Supervised Detox Services - Outpatient	1															
Moving Assistance		2								1						
Non - Emergent Transportation						2										
Opioid Treatment Program		1	1		5	5	8	5								
Optometry					1											
Oral Surgery						2	2									
Outpatient Chemical Dependency - Outpatient Rehabilitation	1							1								
Outpatient Mental Health Clinic							1									
Partial Hospitalization								1								

Anthem HealthPlus Dual Plus (HMO D-SNP) Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Personalized Recovery Oriented Services, Continuing Day Treatment							1	2								
Residential Substance Abuse Treatment Services		1			1			2								
Social Day Care	3	3	3	2		1										
Telehealth						2	2									
Vehicle Modification		1								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.

Strengths, Opportunities for Improvement, and Recommendations

Table 46: Anthem HealthPlus Dual Plus (HMO D-SNP) Plan’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Anthem HealthPlus Dual Plus Plan (HMO D-SNP)’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	One performance improvement project indicator rate reported by Anthem HealthPlus Dual Plus (HMO D-SNP) demonstrated improvement between measurement years 2023 and 2024. One out of four performance improvement indicators reported by Anthem HealthPlus Dual Plus Plan (HMO D-SNP) exceeded their target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Anthem HealthPlus Dual Plus (HMO D-SNP) for measurement year 2024 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	Anthem HealthPlus Dual Plus (HMO D-SNP) met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Three of four performance improvement indicator rates did not reach Anthem HealthPlus Dual Plus (HMO D-SNP)’s target rates.	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	During the 2024 review, Anthem HealthPlus Dual Plus (HMO D-SNP) was not in compliance with one standard of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	Anthem HealthPlus Dual Plus (HMO D-SNP) has the opportunity to reduce their network gaps when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Anthem HealthPlus Dual Plus (HMO D-SNP) 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	Anthem HealthPlus Dual Plus (HMO D-SNP) 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, Anthem HealthPlus Dual Plus (HMO D-SNP) 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	Anthem Health Plus Dual Plus (HMO D-SNP) should ensure its compliance with federal and state Medicaid standards by conducting	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	internal reviews as it prepares for the compliance review conducted by the Department of Health.			
Network Adequacy	It is recommended that Anthem HealthPlus Dual Plus (HMO D-SNP) 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

Centers Plan for Healthy Living

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 47: Centers Plan for Healthy Living’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Centers Plan for Healthy Living’s Response	IPRO’S Assessment of Centers Plan for Healthy Living’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Centers Plan for Healthy Living 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 for Healthy Living’s 2023 Performance Improvement Project on the social determinants of health was successful, as it met and exceeded all goals of providing screening and follow-up interventions for members with positive screening. We successfully implemented the screening in our care management system and provided our staff with education and resources. Centers Plan for Healthy Living continues to conduct screenings, and monitors results to identify areas of improvement. Social determinants of health screening and follow-up has had a positive impact on the health outcomes of our members.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Centers Plan for Healthy Living 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 for Healthy Living should focus</p>	<p>Centers Plan for Healthy Living did not meet the statewide average for three measures in 2023: absence of shortness of breath, absence of severe daily pain, and COVID-19 vaccination. To address these gaps, our care management team focused on providing improved disease management, education, and coordination of care. We implemented a teach-back strategy to identify the effectiveness of our training and education. We continuously monitor our member outcomes and collaborate to identify improvement strategies</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Centers Plan for Healthy Living's Response	IPRO'S Assessment of Centers Plan for Healthy Living's Response
on enhancing 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		
Centers Plan for Healthy Living 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 for Healthy Living continues to conduct auditing & 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 for Healthy Living also has a delegated vendor oversight team that collaborates with vendors to ensure that they are meeting quality standards, and federal and state regulations. Our compliance department participates in regulatory meetings to stay aware of any changes that require an adjustment to current processes.	Addressed.
Network Adequacy		
It is recommended that Centers Plan for Healthy Living 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.	Centers Plan for Healthy Living actively pursues contracts to address identified network gaps. Centers Plan for Healthy Living continues to work to overcome identified challenges to address these gaps that include providers that are unwilling to contract, fail credentialing, are unavailable, or do not maintain good faith negotiations.	Addressed.
Quality-of-Care Survey		
Centers Plan for Healthy Living should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Centers Plan for Healthy Living had no values significantly below the statewide average for the plan evaluation, quality of care, access to care, or timeliness of care measures on the 2023 Managed Long-Term Care Member Satisfaction Survey. We evaluate results of the survey and continue to focus efforts on improving member experience and health outcome measures. Centers Plan for	Addressed.

2023 External Quality Review Recommendation	Centers Plan for Healthy Living's Response	IPRO'S Assessment of Centers Plan for Healthy Living's Response
	Healthy Living also conducts an annual internal member satisfaction survey to identify areas in need of improvement and better understand our members' needs and desires.	

Performance Improvement Project Summaries and Results

Table 48: Centers Plan for Healthy Living's Performance Improvement Project Summary, 2024

Centers Plan for Healthy Living's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ Centers Plan for Healthy Living aims to improve the number of members reporting no depressive feelings based on the Uniform Assessment System Community Health Assessment self-reported mood question for members by three percentage points from the baseline in 2024, and by an additional three percentage points from the 2024 results in 2025. ▪ Centers Plan for Healthy Living aims to monitor the rate members reporting depressive feelings who have a follow-up positive depression screening to ensure appropriate follow-up in each year of the performance improvement project. ▪ Centers Plan for Healthy Living aims to maintain the percentage of members with a documented intervention within two weeks of a positive depression screening at the baseline rate of 100% in each year of the performance improvement project. ▪ Centers Plan for Healthy Living aims to improve the rate of follow ups for members within 60 days of a positive depression screening to 75.00% in 2024, and 80.00% in 2025. ▪ Centers Plan for Healthy Living aims to improve the rate of members with a referral for the behavioral health carved-in benefit within one week of a positive depression screening to 75.00% in 2024, and 80.00% in 2025. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Centers Plan for Healthy Living provided cultural competency training to all staff annually, as well as on initial hire to increase cultural awareness, knowledge, and skills. ▪ Centers Plan for Healthy Living care managers received a comprehensive in-service training on the depression screening and follow-up project including: member resources and education on depression, medication management, and community services for an identified positive screening. ▪ Centers Plan assessed staff competency following each training. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Centers Plan for Healthy Living assigned care management staff to members based on spoken language to bridge gaps in communication by explaining health-related information in a way members can understand.

Centers Plan for Healthy Living's Performance Improvement Project Summary

- Care management provided members with resources and education on depression, medication management, and applicable community services upon an identified positive screening.

Table 49: Centers Plan for Healthy Living's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	61.96%	60.57%	67.96%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	13.89%	33.25%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	100.00%	100.00%	100.00%
Percentage of positive depression screens with follow-up	Not Available	99.07%	80.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	Not Available	100.00%	80.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 50: Centers Plan for Healthy Living's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	51%	44%	45%	71%
No Severe Daily Pain	88%	87%	85%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	77%	76%	75%	78%
Pneumococcal Vaccination	89%	88%	89%	83%
COVID-19 Vaccination	Not Available	45%	57%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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Red shading indicates that the managed care plan's 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 51: Centers Plan for Healthy Living’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	C
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 52: Centers Plan for Healthy Living’s Network Gaps, 2024

Centers Plan for Healthy Living Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care					1	2	2	2								
CORE Community Psychiatric Supports and Treatment							1	1								
Core Psychosocial Rehabilitation								1								
Inpatient Mental Health	1					1										
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1															
Medically Managed Detox Services	2	1			1	1	2	1								
Medically Supervised Detox Services - Outpatient	1					1										
Opioid Treatment Program					3	4	6	5								
Partial Hospitalization					1	1	1	1								
Personalized Recovery Oriented Services, Continuing Day Treatment				1			1	1								
Residential Substance Abuse Treatment Services						2	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 53: Centers Plan for Healthy Living’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Centers Plan for Healthy Living’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	One of three performance improvement project indicator rates reported by Centers Plan for Healthy Living demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of four performance improvement indicator rates reported by Centers Plan for Healthy Living exceeded their target rates and one met their target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Centers Plan for Healthy Living for measurement year 2024 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 for Healthy Living met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of three performance improvement indicators reported by Centers Plan for Healthy Living demonstrated performance decline between measurement years 2023 and 2024. One of four performance improvement indicator rates did not reach Centers Plan for Healthy Living’s target rate.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Centers	X		X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Plan for Healthy Living for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Centers Plan for Healthy Living 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
Recommendations				
Performance Improvement Project, Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy	Centers Plan for Healthy Living's membership was acquired by Anthem HealthPlus Dual Plus (HMO D-SNP) on 01/01/2026. At the time of this report's publishing, Centers Plan for Healthy Living is no longer participating in the New York State Medicaid Managed Care program, and therefore no recommendations were made.			

Elderplan

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 54: Elderplan’s Response to the 2023 External Quality Review Recommendations

2023 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 continued to exceed project goals of social determinants of health completion/care management contact. Care managers completed social determinants of health assessments with every care planning call to identify social barriers/risks, implementing appropriate interventions to address them. The social work coordinator ensured that targeted interventions were continuously developed and followed up on. Ongoing education was provided to all care management staff to ensure member needs were met and outcomes were 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 many comorbidities. In 2024, continued focus was on preventing worsened shortness of breath through heart failure disease management, transitions of care programs, community-based organization partnerships for home visits post-acute episode, certified home health care agency referrals, and ongoing member education on disease progression. Elderplan utilizes plan-do-study-act methodology to determine program effectiveness. Elderplan data for the shortness of breath measure</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Elderplan's Response	IPRO'S Assessment of Elderplan's Response
below the Medicaid Managed Long-term Care program mean.	revealed successful program outcomes, as the rate was 96%, 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 conducts routine monitoring and auditing, focusing on member impact and keeping policies and procedures up to date with federal and state requirements. Elderplan assesses for noncompliance, fraud, waste, and abuse in risk areas of enrollment, call center, care management, pre/post-service requests, appeals and grievances, pharmacy, quality improvement, network/contracting, marketing, and vendor oversight.	Addressed.
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.	Elderplan reviews network gaps monthly by conducting analyses of provider network data system test submissions, network adequacy vendor market data, and provider network terminations. Outreach is conducted to potential providers to commence contract negotiations/ongoing follow up to contract and credential providers. Elderplan also coordinates recruitment with vendors as applicable. This process aids in reducing network gaps identified in the quarterly Statement of Agreement.	Addressed.
Quality-of-Care Survey		
Elderplan should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Elderplan works to ensure member access to care, affecting satisfaction with services including rating of dentist. Issues identified through reporting, satisfaction data, and complaints are addressed through provider outreach, member mailings, health fairs, case	Addressed.

2023 External Quality Review Recommendation	Elderplan's Response	IPRO'S Assessment of Elderplan's Response
	management, and home visit services. Success of these efforts are tracked via utilization and member input. Increase in dental services in 2024 has been observed, indicating improved access to services and better member/provider engagement.	

Performance Improvement Project Summaries and Results

Table 55: Elderplan's Performance Improvement Project Summary, 2024

Elderplan's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of the final measurement year, Elderplan aims to increase the percentage of members reporting no depressive feelings by 8.3 percentage points compared to baseline measurement year. ▪ By the end of the final measurement year, Elderplan aims to increase the percentage of members that had a follow-up positive depression screening after an initial positive depression screening by 33.00% ▪ By the end of the final measurement year, Elderplan aims to increase the percentage of members with a documented intervention within two weeks of a positive depression screening by 33.00% ▪ By the end of the final measurement year, Elderplan aims to increase the percentage of members with a follow up within 60 days of a positive depression screening by 33.00%. ▪ By the end of the final measurement year, Elderplan aims to increase the percentage of referrals for the behavioral health carved-in benefit within one week by 33.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Elderplan implemented a system which alerts care management staff to conduct follow-up screening for members reporting feeling sad, depressed, or hopeless in the last three days. ▪ Elderplan conducted staff trainings annually and as part of new staff orientation on the completion of the Major Depression Inventory Screening Tool. ▪ Elderplan updated current workflows to trigger appropriate interventions based on the Major Depression Inventory Screening Tool score of 25-29 (moderate depression) or 30+ (severe depression).

Table 56: Elderplan’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	77.72%	59.99%	86.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	57.66%	33.00% ¹
Percentage of positive depression screens that have a documented intervention	0.00%	73.53%	33.00%
Percentage of positive depression screens with follow-up	0.00%	73.53%	33.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	0.00%	17.65%	33.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 57: Elderplan’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	43%	37%	41%	71%
No Severe Daily Pain	100%	99%	99%	96%
Pain Controlled	99%	99%	100%	98%
Not Lonely and Distressed	100%	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	76%	78%	76%	78%
Pneumococcal Vaccination	83%	85%	85%	83%
COVID-19 Vaccination	Not Available	81%	90%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 58: Elderplan’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Site Evaluation Focused Survey.

Table 59: Elderplan’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Provider Network Delivery System Focused Survey		
Elderplan failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206
Site Evaluation Focused Survey		
Elderplan failed to produce evidence of vendor oversight for Social Day Care providers to assure compliance with 9 New York Code of Rules and Regulations 6654.20.	Medicaid Advantage Plus Contract Section 21.1 A-B Section 21.5	438.206
Elderplan failed to provide evidence of required annual vendor site visits.	Medicaid Advantage Plus Contract Section 21.1 A-B Section 21.5	438.206

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Elderplan failed to provide evidence of an executed contract that includes Social Day Care requirements.	Medicaid Advantage Plus Contract Section 21.1 A-B Section 21.5	438.206

Network Adequacy Results

Table 60: Elderplan’s Network Gaps, 2024

Elderplan Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care			1	1	2	3	2	3								
Assertive Community Treatment					1	1	1	1								
Audiology Services	1	2	2	2	1	1	2	1								
CORE Community Psychiatric Supports and Treatment					1			1								
CORE Family Support and Training	1			1												
CORE Peer Support					1											
CORE Psychosocial Rehabilitation					1											
Community Transitional Service									1							
Core Psychosocial Rehabilitation								1								
Fiscal Intermediary						1										
Inpatient Chemical Dependency (ASA Inpatient)					1											
Inpatient Mental Health	1	1	1	1												
Institutional Long Term Care (AIDS Skilled Nursing Facility)					1	1		1								
Medically Managed Detox Services	1	1	1		1	1	2	3								
					1											
Medically Supervised Detox Services-Outpatient	1	1														
Opioid Treatment Program		1			6	6	8	8								
Optometry		1	1		1			1								
Oral Surgery	1	1	1	1	1	1	1	1								
Outpatient Chemical Dependency - Outpatient Rehabilitation	1	1	1	1												
Outpatient Mental Health Clinic					1	1	1	1								
Outpatient Mental Health Clinic-State Operated						2										

Elderplan Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Partial Hospitalization					1		1	2								
Personalized Recovery Oriented Services, Continuing Day Treatment				1			1	1								
Residential Substance Abuse Treatment Services		1	1	1	1	2	2	2								
Social Day Care				1	2	1	2									
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.

Strengths, Opportunities for Improvement, and Recommendations

Table 61: 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 2024.			
	Four of five performance improvement project indicator rates reported by Elderplan demonstrated improvement between measurement years 2023 and 2024. Three of five performance improvement project indicators exceeded Elderplan’s target rates.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Elderplan for measurement year 2024 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
Opportunities for Improvement				
Performance Improvement Project	One of five performance improvement project indicator rates reported by Elderplan demonstrated performance decline between measurement years 2023 and 2024. Two of five performance improvement indicator rates did not reach Elderplan’s target rate.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Elderplan for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review activities, Elderplan was not in compliance with one standard of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	Elderplan has the opportunity to reduce their gaps in their network that were identified in		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.			
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

ElderServe MAP

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, ElderServe MAP operated under the name RiverSpring.

Table 62: ElderServe MAP’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	ElderServe MAP’s Response	IPRO’S Assessment of ElderServe MAP’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, ElderServe MAP 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 to determine why the intervention is not effective and to identify new interventions that may better serve the goals set to improve the members’ outcomes. This process is an ongoing component of quality assurance</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>ElderServe MAP 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, ElderServe MAP should focus on</p>	<p>Community Health Assessment data and member satisfaction surveys are reviewed for areas of opportunity to improve member outcomes. For example, ElderServe MAP members are below statewide average in receiving vaccines and pain controlled. In response, a pain assessment was added to the care manager assessment so that members’ pain is addressed with interventions to reduce or alleviate members’ pain. Additionally, ElderServe MAP has partnered with community providers to provide</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	ElderServe MAP's Response	IPRO'S Assessment of ElderServe MAP's Response
enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	immunizations to members in their home.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
ElderServe MAP 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.	ElderServe MAP conducts monthly auditing and monitoring of operations as part of its quality and compliance program. Results are reported to stakeholders at minimum quarterly 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.
Network Adequacy		
It is recommended ElderServe MAP 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.	To address this recommendation, ElderServe MAP health pursues contracts with providers in the specified counties to fill the identified gaps in our network. This will involve identifying available providers, negotiating contracts, and ensuring these contracts meet the needs outlined in our statement of agreement. By doing so, we aim to enhance our network's comprehensiveness and better serve our members.	Addressed.
Quality-of-Care Survey		
Despite its small sample size for the member satisfaction survey, ElderServe MAP should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Member satisfaction is monitored internally by direct member feedback, member advisory committees, meetings with the care manager and through tracking member complaints. Providers with multiple complaints are removed from the network. ElderServe staff are educated on topics such as	Addressed.

2023 External Quality Review Recommendation	ElderServe MAP's Response	IPRO'S Assessment of ElderServe MAP's Response
	advance directives to support the members in making health care and advocacy decisions. As a result, our members continue to rate us above statewide average in their experience with care managers and home care	

Performance Improvement Project Summaries and Results

Table 63: ElderServe MAP's Performance Improvement Project Summary, 2024

ElderServe MAP's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of 2025, ElderServe MAP aims to increase the percentage of continuously enrolled Medicaid Advantage Plus members reporting no depressive feelings to 70.00%. ▪ By the end of 2025, ElderServe MAP aims to increase the percentage of members that had a follow up within two weeks of a positive depression screening to 5.00%. ▪ By the end of 2025, ElderServe MAP aims to increase the percentage of members with a documented intervention after a positive depression screening to 60.00%. ▪ By the end of 2025, ElderServe MAP aims to increase the percentage members with a follow up after a positive depression screening to 60.00%. ▪ By the end of 2025, ElderServe MAP aims to increase the percentage of continuously enrolled members referred for the behavioral health carved-in benefit within one week of a positive depression screening to 20.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Developed an alert system to notify the interdisciplinary team when the member should complete a follow-up depression screening. ▪ Added intervention fields and dropdown options within the electronic medical record to document and report member-specific depression interventions, with audit processes to validate data accuracy. ▪ Provided annual refresher training to nurse care managers and managed long-term care staff on depression, evidence-based practices, and community resources. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Educated members with positive depression screens on the impact of depression, available benefits, and community resources, incorporating member feedback to improve outreach.

Table 64: ElderServe MAP’s Performance Improvement Project Indicator Summary, Measurement Years, 2023 - 2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	66.10%	64.42%	70.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	9.38%	5.00% ¹
Percentage of positive depression screens that have a documented intervention	Not Available	66.67%	60.00%
Percentage of positive depression screens with follow-up	Not Available	66.67%	60.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	Not Available	Not Applicable ²	20.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

² No members were eligible or required an external behavioral health benefit referral.

Performance Measure Results

Table 65: ElderServe MAP’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	48%	49%	50%	71%
No Severe Daily Pain	100%	96%	99%	96%
Pain Controlled	89%	87%	91%	98%
Not Lonely and Distressed	98%	97%	97%	99%
Effectiveness of Care				
Influenza Vaccination	80%	85%	78%	78%
Pneumococcal Vaccination	71%	79%	78%	83%
COVID-19 Vaccination	Not Available	84%	78%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 66: ElderServe MAP’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	C
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 67: ElderServe MAP's Network Gaps, 2024

ElderServe MAP Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1		1	1	1	1	1	1								
Assertive Community Treatment	5			4	1			2								
Audiology Services					1	1	1	1								
CORE Community Psychiatric Supports and Treatment	6		7	7												
CORE Family Support and Training	6		7	7												
CORE Peer Support	6		7	7												
CORE Psychosocial Rehabilitation	6		7	7												
Certified Home Health: Home Based Medical Social Services						1										
Community Transitional Service					1											
Comprehensive Psychiatric Emergency Program	5			5					2			2				
Fiscal Intermediary	1		1	1												
General Dentistry	2		7	7												
Home Delivered and Congregate Meals					1		1	1								
Home and Community Support Services	1															
Inpatient Chemical Dependency (ASA Inpatient)	7			5												
Inpatient Mental Health	7			6												
Institutional Short Term Care	1		1	1	1		1	1								
Medically Managed Detox Services	6			6												
Medically Supervised Detox Services - Inpatient	4			4					2			2				
Medically Supervised Detox Services - Outpatient	3			2					2			2				
Opioid Treatment Program	6		6	7	1		1									
Optometry			1	2	1		2	1								
Oral Surgery	2		7	1												
Outpatient Chemical Dependency - Clinic	4			6	3			1								

ElderServe MAP Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Outpatient Chemical Dependency - Outpatient Rehabilitation	4			4					1			1				
Outpatient Mental Health Clinic	7			7												
Outpatient Mental Health Clinic - State Operated	6			5												
Partial Hospitalization	7			7												
Personalized Recovery-Oriented Services, Continuing Day Treatment	5			6	1			1								
Podiatry							1	1								
Residential Substance Abuse Treatment Services	5			6	1			1					1			
Telehealth	7	1	7	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 68: ElderServe MAP’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ElderServe MAP’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	Three of five performance improvement indicators exceeded ElderServe MAP’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	ElderServe MAP met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One performance improvement indicator reported by ElderServe MAP demonstrated performance decline between measurement year 2023 and 2024. One of five performance improvement indicator rates did not reach ElderServe MAP’s target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for ElderServe MAP for measurement year 2024 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	ElderServe MAP 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
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	In the ongoing performance improvement project, ElderServe MAP 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	ElderServe MAP 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, ElderServe MAP 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	ElderServe MAP 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 ElderServe MAP 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

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 69: Hamaspik’s Response to the 2023 External Quality Review Recommendations

2023 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>Now fully available and integrated into the community, we utilize social care networks as a resource for our members to support their social determinants of health needs. We assist members in connecting to their county’s social care networks for assessment, as needed. Internal resources are also maintained for staff and members, and interventions can be implemented and carried out, as needed</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 continuously downloads quality data from our Uniform Assessment System analyzer tool to identify current quality measure performance up against state averages. Based on our rates we launch campaigns and revise internal workflows to address areas where we may be lagging state averages and track our improvement trajectory. Additionally, Hamaspik reviews IPRO survey outcomes as received and shapes quality improvement initiatives to address and impact the areas in which our members are reporting negatively.</p>	<p>Addressed.</p>

2023 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/Medicaid Advantage Program compliance. Audits include care management contact frequency/documentation, enrollment/disenrollment documentation, utilization review, appeals timeliness and documentation, consumer directed personal assistance services documentation, member services standards for timeliness and accuracy, utilization of key services that determine member eligibility, and others.	Addressed.
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.	Hamaspik actively monitors our network for sufficiency per Centers for Medicare & Medicaid Services and New York State Department of Health guidelines. We ensure an adequate network of providers for each specialty in each county of service. Since this 2023 review was complete, we have contracted new providers in each county and have closed many of the gaps. Remaining gaps are insufficient providers in the service area.	Addressed.
Quality-of-Care Survey		
Hamaspik should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	We conduct a post-call survey surveying all members who call into Hamaspik. Callers are asked questions about their care and experience with Hamaspik and its representatives. Hamaspik contacts all members with negative responses to conduct a deeper investigation into their	Addressed.

2023 External Quality Review Recommendation	Hamaspik's Response	IPRO'S Assessment of Hamaspik's Response
	dissatisfaction and uses this information to improve workflows and plan processes Additionally, Hamaspik fields the IPRO survey as well as the consumer assessment of healthcare providers and systems survey and utilizes the insights from these results to improve its quality.	

Performance Improvement Project Summaries and Results

Table 70: Hamaspik's Performance Improvement Project Summary, 2024

Hamaspik's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of the final measurement year, Hamaspik aims to increase the number of members with no depressive feelings for members by 14.00%. ▪ By the end of the final measurement year, Hamaspik aims to track all members who reported depressive feelings on the Uniform Assessment System Community Health Assessment and also reported depressive feelings on a follow-up depression screening. ▪ By the end of the final measurement year, Hamaspik aims to have a documented intervention within two weeks of a positive depression screening for 85.00% of members. ▪ By the end of the final measurement year, Hamaspik aims to follow up with 85.00% of all members with positive depression screenings within 60 days. ▪ By the end of the final measurement year, Hamaspik aims to increase referrals to the Behavioral Health carved-in benefit from a non-reportable number to 80.00% of members who have had a positive depression screening. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Created an automated report to monitor and track members across all performance indicators. ▪ Encouraged care managers and nurses to have conversations about depression with members in a manner that makes the member feel comfortable and not stigmatized. ▪ Care managers and nurses received clinical trainings on the signs and symptoms of depression to identify struggling members and intervene and follow up appropriately. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Created member education tools highlighting key benefits of treating depression and resources on to how to do so.

Hamaspik's Performance Improvement Project Summary

- Collaborated with Licensed Home Care Services Agencies and in-network providers to engage members with positive depression screenings and assist in connecting them to the right resources and help.

Table 71: Hamaspik's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	70.96%	65.07%	85.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	27.72%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	Not Available	61.63%	85.00%
Percentage of positive depression screens with follow-up	Not Available	91.57%	85.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	Not Available	29.07%	80.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 72: Hamaspik's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	85%	69%	74%	71%
No Severe Daily Pain	98%	98%	100%	96%
Pain Controlled	98%	98%	99%	98%
Not Lonely and Distressed	98%	98%	100%	99%
Effectiveness of Care				
Influenza Vaccination	81%	77%	75%	78%
Pneumococcal Vaccination	77%	80%	83%	83%
COVID-19 Vaccination	Not Available	67%	62%	80%

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 73: Hamaspik’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	NC
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Management Services Agreement Focused Survey.

Table 74: Hamaspik’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Provider Network Delivery System Focused Survey		
Hamaspik failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus (MAP) services. See attached document for an inclusive list of deficient services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206
Management Services Agreement Focused Study		
Hamaspik failed to submit to the Department of Health for review and approval the Beacon/Carelon Management Services Agreement at least 90 days prior to the management contract’s proposed effective date of January 1, 2024. Rather, the Beacon/Carelon Management Services Agreement was submitted to the Department of Health on May 22, 2024.	Medicaid Advantage Plus Contract Section 22.4 Section 22.9 Section 98.1-11(k)(m)	438.230

Network Adequacy Results

Table 75: Hamaspik’s Network Gaps, 2024

Hamaspik Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1	3	2	2	5	5	4	4								
Assertive Community Treatment			1		1		1									
Audiology Services			1	1	1	1		2								
Certified Home Health: Home Based Occupational Therapy							1									
Certified Home Health: Home Based Physical Therapy							1									
Certified Home Health: Home Based Speech Therapy							1									
CORE Community Psychiatric Supports and Treatment	1		1	2			1	1								
CORE Family Support and Training					1		2	1								
CORE Peer Support					1		1	1								
Core Psychosocial Rehabilitation					1		1	2								
Fiscal Intermediary		3				1										
Home Delivered and Congregate Meals					1	3										
Inpatient Mental Health	1		1													
Institutional Long Term Care						1										
Institutional Long Term Care (AIDS Skilled Nursing Facility)	6	1	1	1	1	2			3							
Institutional Long Term Care (Vent Skilled Nursing Facility)	1															
Institutional Short Term Care						1										
Medically Managed Detox Services			1		2		2									
Medically Supervised Detox Services- Outpatient	1															
Moving Assistance										1						

Hamaspik Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Opioid Treatment Program	1	1			7	7	10	10								
Optometry	2	2	2	2												
Oral Surgery		1	1	1	2	1	1	2								
Outpatient Chemical Dependency - Outpatient Rehabilitation	1						1	2								
Outpatient Mental Health Clinic							1	1								
Outpatient Mental Health Clinic - State Operated				1			4									
Partial Hospitalization					1		1									
Personalized Recovery Oriented Services, Continuing Day Treatment			2	1			1	2								
Residential Substance Abuse Treatment Services			1		1		2									
Social Day Care						1										
Social and Environmental Support						13	5									
Telehealth	2	6	2	2	4	3	1	1								
Therapy: Speech and Language	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 76: 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 2024.			
	One of four performance improvement project indicator rates exceeded Hamaspik’s target rate.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik for measurement year 2024 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
Opportunities for Improvement				
Performance Improvement Project	One performance improvement project indicator rate reported by Hamaspik demonstrated performance decline between measurement years 2023 and 2024. Three of four performance improvement indicator rates did not reach Hamaspik’s target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review activities, Hamaspik was not in compliance with two standards of 42 Code Federal Regulations Part 438.	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 type(s) is available in the county identified in the Statement of Agreement.		X	X
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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 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

Healthfirst CompleteCare

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, Healthfirst CompleteCare operated under the name MHI Healthfirst.

Table 77: Healthfirst CompleteCare’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Healthfirst CompleteCare’s Response	IPRO’S Assessment of Healthfirst CompleteCare’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Healthfirst CompleteCare 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 leverage an automated report to flag members due for a social determinant of health assessment and/or missing an intervention. They use an enhanced seven-domain assessment and care plan builder in our electronic health record system, TruCare. Through clinical coaching, system training, and Power Business Intelligence reporting, care managers have improved the timeliness of conducting assessments, implementing appropriate interventions, and completing follow-up care.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Healthfirst CompleteCare 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 CompleteCare</p>	<p>Healthfirst CompleteCare remains focused on integrating performance measures into everyday care processes. Care managers leverage clinical and social determinants data to conduct targeted outreach and close care gaps. Regular audits of health assessment data are used to drive refinements in care strategies. Our clinical teams routinely review measure- and member-level results, adjust approaches, and are recognized for strong performance. Ongoing training is provided to support continuous improvements.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Healthfirst CompleteCare's Response	IPRO'S Assessment of Healthfirst CompleteCare's Response
should focus on enhancing 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		
Healthfirst CompleteCare 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 Healthfirst CompleteCare's ongoing preparation activities for the Department of Health compliance review, all relevant business units reviewed prior results to confirm compliance with federal and state Medicaid standards. In addition, the compliance and regulatory teams worked collaboratively to monitor and review continuing compliance.	Addressed.
Network Adequacy		
It is recommended Healthfirst CompleteCare 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.	To address identified gaps, Healthfirst CompleteCare will continue to actively pursue and engage all available qualified providers for contracting, with the goal of ensuring comprehensive network coverage across all affected counties.	Addressed.
Quality-of-Care Survey		
Healthfirst CompleteCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	In response to the 2023 survey results, Healthfirst CompleteCare did some surveying to gather feedback. Insights were shared with care managers to help tailor member interactions and home health agencies to address service issues such as consistency of care and punctuality. We remained committed to assessing these areas to identify opportunities for improvement in member satisfaction.	Addressed.

Performance Improvement Project Summaries and Results

Table 78: Healthfirst CompleteCare’s Performance Improvement Project Summary, 2024

Healthfirst Complete Care’s Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
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
<u>Aims</u>
<ul style="list-style-type: none">▪ By the end of 2025, Healthfirst CompleteCare aims to improve depression screening rates for members by 4.74 percentage points, meeting the New York State 2023 90th percentile benchmark of 17.00% for the HEDIS electronic clinical data systems measure.▪ By the end of 2025, Healthfirst CompleteCare aims to increase the rate of members with depression who receive treatment by at least 4.86 percentage points, reaching their goal of 92.00% and surpassing the Healthy People 2030 target of 69.5%.▪ By the end of 2025, Healthfirst CompleteCare aims to improve follow-up rates after positive depression screenings for members by 5.26 percentage points, exceeding the New York State 2023 90th percentile benchmark of 84.00% for the HEDIS electronic clinical data systems measure.▪ By the end of 2025, Healthfirst CompleteCare aims to increase the percentage of continuously enrolled members who receive a behavioral health carved-in referral within one week of a positive depression screening by 7.00%.
<u>Managed Care Plan-Focused 2024 Interventions</u>
<ul style="list-style-type: none">▪ Developed internal processes and workflows that identify and track a member’s depression screening results, as well as the care management follow-up activities.▪ Improved the functionality of the Patient Health Questionnaire-9 screening tool in TruCare by consolidating its previously embedded versions (located within various care management assessments) into a single, centralized screening tool.▪ Constructed a job aid and facilitated staff trainings on the new workflow which instruct staff on when/how to intervene after a member has a specific score on the Patient Health Questionnaire-9 Screening Tool.
<u>Member-Focused 2024 Interventions</u>
<ul style="list-style-type: none">▪ Members received an intervention(s) relevant to their Patient Health Questionnaire-9 Screening Tool score level, as well as education on depression and behavioral health resources by care management staff during telephonic outreach.

Table 79: Healthfirst CompleteCare’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	84.85%	86.10%	89.09%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	12.26%	11.82%	17.00% ¹
Percentage of positive depression screens that have a documented intervention	87.14%	92.68%	92.00%
Percentage of positive depression screens with follow-up	92.74%	99.77%	98.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	25.44%	74.79%	80.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 80: Healthfirst CompleteCare’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	87%	84%	87%	71%
No Severe Daily Pain	99%	97%	99%	96%
Pain Controlled	96%	96%	97%	98%
Not Lonely and Distressed	96%	97%	99%	99%
Effectiveness of Care				
Influenza Vaccination	73%	73%	76%	78%
Pneumococcal Vaccination	71%	75%	78%	83%
COVID-19 Vaccination	Not Available	73%	88%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 81: Healthfirst CompleteCare’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Table 82: Healthfirst CompleteCare’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Healthfirst CompleteCare failed to meet the minimum requirements for network adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206

Network Adequacy Results

Table 83: Healthfirst CompleteCare’s Network Gaps, 2024

Healthfirst CompleteCare Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1	1	3	3	1		1	1								
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															
Institutional Long Term Care					1			1								
Institutional Long Term Care (AIDS Skilled Nursing Facility)	2			1					1							
Institutional Long Term Care (Vent Skilled Nursing Facility)								1					1			
Institutional Short Term Care					1			1								
Medically Managed Detox Services			1	1		1	1									
Opioid Treatment Program					3	3	6	4								
Oral Surgery			1	1	1											
Outpatient Chemical Dependency - Outpatient Rehabilitation			1	1			1	1								
Outpatient Mental Health Clinic - State Operated						1	1	2								
Personalized Recovery Oriented Services, Continuing Day Treatment							1							1		
Private Duty Nursing							1									
Residential Substance Abuse Treatment Services	1	1	2	2			1									
Social Day Care	1		2	2						1						
Therapy: Speech and Language	1	1	1		1	1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 84: Healthfirst CompleteCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Healthfirst CompleteCare’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	Four of five performance improvement project indicator rates reported by Healthfirst CompleteCare demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of five performance improvement project indicator rates exceeded Healthfirst CompleteCare’s target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Healthfirst CompleteCare for measurement year 2024 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	Healthfirst CompleteCare met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Three of five performance improvement indicator rate did not reach Healthfirst CompleteCare’s target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Healthfirst CompleteCare for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal	During the 2024 review, Healthfirst CompleteCare was not in compliance with one	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Managed Care Standards	standard of 42 Code Federal Regulations Part 438.			
Network Adequacy	Healthfirst CompleteCare 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Healthfirst CompleteCare 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	Healthfirst CompleteCare 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 CompleteCare 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	Healthfirst CompleteCare 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 Healthfirst CompleteCare 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

MetroPlus Ultra Care

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 85: MetroPlus Ultra Care’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	MetroPlus Ultra Care’s Response	IPRO’S Assessment of MetroPlus Ultra Care’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, MetroPlus Ultra 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>MetroPlus Ultra Care continuously monitors and reviews social determinants of health at the time of routine Uniform Assessment System assessments. Care managers address social determinants of health needs during monthly member calls and provide interventions and available resources. Continuation of this project enables ongoing quality improvement in social determinants of health screening and follow-up. Monthly reports are run to track data and is also shared with staff. MetroPlus Ultra Care conducts refresher trainings as needed and based on any trends that are identified.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>MetroPlus Ultra 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, MetroPlus Ultra Care should focus on enhancing areas of</p>	<p>MetroPlus Ultra Care utilizes the assessment analysis platform Lenavi to continuously monitor, and track care gaps noted on the Uniform Assessment System assessment. After the assessor and quality teams identify care gaps, the care management team develops an individualized plan of care with the member, establishing achievable goals and interventions to improve health outcomes. Interventions are examined during routine contacts with members. Refresher trainings are provided to staff on addressing/closing care gaps.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	MetroPlus Ultra Care's Response	IPRO'S Assessment of MetroPlus Ultra 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		
MetroPlus Ultra 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.	MetroPlus Ultra Care continues to maintain a compliance program with an assigned compliance specialist to ensure adherence to all applicable requirements. Through a risk assessment, MetroPlus Ultra Care' 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 Ultra Care governing body.	Addressed.
Network Adequacy		
It is recommended MetroPlus Ultra 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.	The MetroPlus Ultra Care contracting team partners with the provider network operations team to identify network gaps as reported through the Provider Network Data System submissions. If gaps are identified, the contracting team identifies providers who may fill the gaps and reaches out to the provider in an effort to establish a contractual relationship. This process is repeated each calendar quarter. Additionally, MetroPlus Ultra Care routinely monitors market data and other provider directories for contracting opportunities.	Addressed.
Quality-of-Care Survey		
Despite its small sample size for the member satisfaction survey, MetroPlus Ultra Care should evaluate member satisfaction and address adverse member	MetroPlus Ultra Care increased its monitoring of member satisfaction by creating an ad hoc satisfaction survey using the performance feedback platform. Survey results	Addressed.

2023 External Quality Review Recommendation	MetroPlus Ultra Care's Response	IPRO'S Assessment of MetroPlus Ultra Care's Response
<p>experience with areas linked to quality, timeliness, and access to care.</p>	<p>are monitored regularly to identify dissatisfiers and guide improvement strategies by the Managed Long-Term Care quality team, which are then shared with the care manager. During monthly calls, member concerns are addressed to improve quality, timeliness, and access to care.</p>	

Performance Improvement Project Summaries and Results

Table 86: MetroPlus Ultra Care’s Performance Improvement Project Summary, 2024

MetroPlus Ultra Care’s Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
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
<u>Aims</u>
<ul style="list-style-type: none">▪ By the end of 2025, MetroPlus Ultra Care aims to increase the percentage of members reporting no depressive feelings from to 95.00%.▪ By the end of 2025, MetroPlus Ultra Care aims to address all members identified with a positive depression screening on the Uniform Assessment System Community Health Assessment with the completion of a Patient Health Questionnaire-9, tracking interventions every six weeks, and applying any additional follow-ups based on intervention results.▪ By the end of 2025, MetroPlus Ultra Care aims to increase the percentage of documented interventions for members within two weeks of a positive depression screening to 66.00%.▪ By the end of 2025, MetroPlus Ultra Care aims to increase the percentage of members who receive a follow up within 60 days of a positive depression screening to 97.00%.▪ By the end of 2025, MetroPlus Ultra Care aims to increase the percentage of continuously enrolled members a timely referral for the behavioral health carved-in benefit after a positive depression screening to 30.00%.
<u>Managed Care Plan-Focused 2024 Interventions</u>
<ul style="list-style-type: none">▪ Provided training presentations and online courses (via Lenavi software) to staff on the impact of depression on members’ health, social, and functional status.▪ Introduced and trained staff on the Patient Health Questionnaire-9 Screening Tool.▪ Implemented a standardized process for administering Patient Health Questionnaire-9 Screening Tool to members with positive screening for depression within the Uniform Assessment System Community Health Assessment.▪ Established a consistent protocol for timely referral of members with positive Patient Health Questionnaire-9 Screening Tool results to appropriate services and supports.▪ Developed reports tracking Patient Health Questionnaire-9 Screening Tool completion by business line, including scores and responses.

Table 87: MetroPlus Ultra Care’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	90.42%	92.50%	95.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	9.57%	100.00%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	68.35%	100.00%	66.00%
Percentage of positive depression screens with follow-up	50.63%	100.00%	97.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	0.00%	66.67%	30.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 88: MetroPlus Ultra Care’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	Small Sample	86%	85%	71%
No Severe Daily Pain	Small Sample	100%	95%	96%
Pain Controlled	Small Sample	97%	91%	98%
Not Lonely and Distressed	Small Sample	100%	95%	99%
Effectiveness of Care				
Influenza Vaccination	Small Sample	76%	71%	78%
Pneumococcal Vaccination	Small Sample	76%	83%	83%
COVID-19 Vaccination	Not Available	89%	82%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 89: MetroPlus Ultra Care’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2024 Focused ¹
438.56: Disenrollment: Requirements and Limitations	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 90: MetroPlus Ultra Care’s Network Gaps, 2024

MetroPlus Ultra Care Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Medical Social Services					4											
Licensed Home Health Care: Home Based Speech Therapy					4											
Medically Managed Detox Services					1			1								
Opioid Treatment Program					1		1	1								
Private Duty Nursing	1	1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 91: MetroPlus Ultra Care’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus Ultra Care’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	All five performance improvement project indicator rates reported by MetroPlus Ultra Care demonstrated improvement between measurement years 2023 and 2024. Three of four performance improvement indicator rates exceeded MetroPlus Ultra Care’s target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for MetroPlus Ultra Care for measurement year 2024 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review, MetroPlus Ultra Care was in compliance with one standard of 42 Code Federal Regulations Part 438 that was reviewed.	X	X	X
Network Adequacy	MetroPlus Ultra Care met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement indicator rates did not reach MetroPlus Ultra Care’s target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for MetroPlus Ultra Care for measurement year 2024 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	MetroPlus Ultra 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.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MetroPlus Ultra 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	MetroPlus Ultra 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, MetroPlus Ultra 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	MetroPlus Ultra 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 MetroPlus Ultra 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

Senior Whole Health

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 92: Senior Whole Health’s Response to the 2023 External Quality Review Recommendations

2023 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 regularly analyzes health assessment data to enhance quality assurance and performance improvement plans by identifying gaps in care for social determinants of health, increasing the volume of assessments for new enrollees, and implementing appropriate social determinants of health interventions. Senior Whole Health continues to provide those services for members within their own zip codes. We believe our approach has identified needs, improved rates, and optimized member outcomes with optimal impact.</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 care where its rates are below</p>	<p>Senior Whole Health will continue to analyze health assessment data to enhance quality assurance. Senior Whole Health has identified trends, quality care gaps, and strengthened interventions with those members determined to be at-risk, to utilize best practices which ensure maintenance of high-performance rates.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Senior Whole Health's Response	IPRO'S Assessment of Senior Whole Health's Response
the Medicaid Managed Long-term Care program mean.		
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 maintains a proactive and structured approach to compliance through ongoing monitoring, regular training, and risk-based auditing. Guided by continuous risk assessments, the compliance program ensures accountability, drives corrective actions, and fosters a culture of compliance organization wide.	Addressed.
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	The network department is actively pursuing contracts to close each listed gap. The network department continues to monitor, and to ensure no additional network adequacy gaps arise. Additionally, Senior Whole Health continues to grow its Medicaid Advantage Plus provider network in each required specialty.	Addressed.
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.	Senior Whole Health has identified member satisfaction as a concern. We analyzed the root causes and reviewed member experiences, focusing on appointing someone for health decisions, requests to see medications, member ratings of the health plan, and the timeliness of care. When members had negative experiences, we gathered their feedback from the quality questionnaire and provided care management interventions that support strengthening their relationship with their care manager.	Addressed.

Performance Improvement Project Summaries and Results

Table 93: Senior Whole Health's Performance Improvement Project Summary, 2024

Senior Whole Health's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By the end of 2025, Senior Whole Health aims to increase the percentage of continuously enrolled members reporting no depressive feelings by 5.00% from the baseline measurement year.▪ By the end of 2025, Senior Whole Health aims to implement the Patient Health Questionnaire-9 Screening Tool, and to monitor and trend the percentage of members reporting depressive feelings that had a follow-up positive depression screen.▪ By the end of 2025, Senior Whole Health aims to increase the percentage of members with a documented intervention within two weeks of a positive depression screening by 5.00% from the 2024 interim rate as no baseline data is available.▪ By the end of 2025, Senior Whole Health aims to increase the percentage of members with a follow up within 60 days of a positive depression screening by 5.00% from the 2024 interim rate as no baseline data is available.▪ By the end of 2025, Senior Whole Health aims to increase the percentage of members with a referral for the behavioral health carved-in benefit within one week by 5.00% from the 2024 interim rate as no baseline data is available.
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Implemented a standardized depression screening tool (Patient Health Questionnaire-9).▪ Developed and implemented an “At Risk for Depression” alert within the Quality Questionnaire to prompt the care management team to request for the member to complete a depression screening.▪ Trained care management and quality staff on the current end to end depression workflow.
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Senior Whole Health sent educational fliers and conducted telephonic care management follow-up to confirm member’s understanding of depression.

Table 94: Senior Whole Health's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	78.89%	89.41%	82.80%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	11.10%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	0.00%	0.00%	5.00%
Percentage of positive depression screens with follow-up	0.00%	0.00%	5.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	0.00%	0.00%	5.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 95: Senior Whole Health's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	81%	83%	84%	71%
No Severe Daily Pain	100%	99%	100%	96%
Pain Controlled	98%	100%	99%	98%
Not Lonely and Distressed	100%	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	84%	88%	88%	78%
Pneumococcal Vaccination	83%	89%	90%	83%
COVID-19 Vaccination	Not Available	93%	94%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 96: Senior Whole Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	NC
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Table 97: Senior Whole Health’s Compliance Review Summary of Results, 2024

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 Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206
Senior Whole Health failed to provide records and information within two business days of a written request.	Medicaid Advantage Plus Contract Section 19.3	438.207

Network Adequacy Results

Table 98: Senior Whole Health’s Network Gaps, 2024

Senior Whole Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care							2	1								
Assertive Community Treatment			4	1			1	3								
Audiology Services			1	1			1	1								
CORE Community Psychiatric Supports and Treatment			3				4	2								
CORE Family Support and Training			2				3	2								
CORE Peer Support			3	1			1	1								
CORE Psychosocial Rehabilitation			2				1	2								
Comprehensive Psychiatric Emergency Program			1	1												
Consumer Directed Personal Care							1									
Home Delivered and Congregate Meals			1				1									
Inpatient Chemical Dependency (ASA Inpatient)	1	1	3	4	2	2	2	1								
Inpatient Mental Health			1	2			2	1								
Institutional Long Term Care							1	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							2									
Medically Managed Detox Services	1	1	4	4	1	2		1								
Medically Supervised Detox Services - Inpatient	3	3		2							1	1				
Medically Supervised Detox Services - Outpatient	2	2		1							1			3	3	
Opioid Treatment Program			2	2	4	4	7	7								
Optometry	4															
Outpatient Chemical Dependency – Clinic					4	4	4	7								

Senior Whole Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Outpatient Chemical Dependency - Outpatient Rehabilitation	1	1	1	2		1	2	2								
Outpatient Mental Health Clinic					1	1	3	4								
Outpatient Mental Health Clinic - State Operated	3	3	4	7	1	1		1								
Partial Hospitalization			3	2		1	1	2			1					1
Personal Emergency Response							1									
Personalized Recovery Oriented Services, Continuing Day Treatment			2	2	1	1	2	3								
Podiatry	4						1									
Residential Substance Abuse Treatment Services	2	3	4	3	1						1					
Social Day Care			2	2												
Social and Environmental Support			1	1			2	1								
Telehealth		4	8		1		1									
Therapy: Respiratory			2	2												
Therapy: Speech and Language			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.

Strengths, Opportunities for Improvement, and Recommendations

Table 99: 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 2024.			
	Two of five performance improvement project indicator rates reported by Senior Whole Health demonstrated improvement between measurement years 2023 and 2024. One of four performance improvement indicator rates exceeded Senior Whole Health’s target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Senior Whole Health for measurement year 2024 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 Whole Health met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Three of four performance improvement indicator rate did not reach Senior Whole Health’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2024 review, Senior Whole Health was not in compliance with two standards of 42 Code Federal Regulations Part 438.	X	X	X
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

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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 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.	X	X	X
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

United Healthcare

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

United Healthcare was established in 2024 but had no enrollment until May of 2025.

Performance Improvement Project Summaries and Results

United Healthcare was established in 2024 but had no enrollment until May of 2025.

Performance Measure Results

United Healthcare was established in 2024 but had no enrollment until May of 2025.

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

United Healthcare was established in 2024 but had no enrollment until May of 2025.

Network Adequacy Results

Table 100: United Healthcare’s Network Gaps, 2024

United Healthcare Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care			2	2			1	1								
Comprehensive Psychiatric Emergency Program			4	3				1			1	1				
Core Community Psychiatric Supports and Treatment							1	1								
General Dentistry							1									
Inpatient Mental Health							1	1								
Medically Managed Detox Services			4	4							1	1				
Medically Supervised Detox Services - Inpatient			1	1			4	4								
Opioid Treatment Program							4	4								
Oral Surgery							1	1								
Outpatient Mental Health Clinic - State Operated							4	4								
Partial Hospitalization							4	4				1			1	
Residential Substance Abuse Treatment Services							1	1								
Social Day Care							2	3								
Social and Environmental Support								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.

Strengths, Opportunities for Improvement, and Recommendations

Table 101: United Healthcare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Network Adequacy	United Healthcare met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Network Adequacy	United Healthcare 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
Recommendations				
Network Adequacy	It is recommended that United Healthcare 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

VillageCareMAX Medicare Total Advantage

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, VillageCareMAX Medicare Total Advantage operated under the name VillageCare.

Table 102: VillageCareMAX Medicare Total Advantage’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	VillageCareMAX Medicare Total Advantage’s Response	IPRO’S Assessment of VillageCareMAX Medicare Total Advantage’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VillageCareMAX Medicare Total Advantage 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>VillageCareMAX Medicare Total Advantage continued to monitor the social determinants of health performance improvement project. VillageCareMAX Medicare Total Advantage held health equity subcommittee meetings throughout the year. The health equity subcommittee used data from the social determinants of health assessments, as well as other sources of data to identify health disparities. The subcommittee developed and implemented interventions for the health disparities identified during the subcommittee meetings.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>VillageCareMAX Medicare Total Advantage 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>VillageCareMAX Medicare Total Advantage has utilized the findings from the Department of Health's analysis to inform our internal quality assurance and performance improvement program. Monthly meetings are set with each department to review quality measures and troubleshoot any risk areas. Tracking and data analysis is conducted to ensure members are receiving quality care. If needed,</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	VillageCareMAX Medicare Total Advantage's Response	IPRO'S Assessment of VillageCareMAX Medicare Total Advantage's Response
<p>unfavorable health outcomes. To address this, VillageCareMAX Medicare Total Advantage should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>corrective action plans take place to decrease risk.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>VillageCareMAX Medicare Total Advantage 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>VillageCareMAX Medicare Total Advantage'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 to resolution.</p>	<p>Addressed.</p>
<p>Network Adequacy</p>		
<p>It is recommended VillageCareMAX Medicare Total Advantage 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.</p>	<p>VillageCareMAX Medicare Total Advantage's network team regularly pursues new provider contracts to expand provider network.</p>	<p>Addressed.</p>
<p>Quality-of-Care Survey</p>		
<p>VillageCareMAX Medicare Total Advantage should evaluate member satisfaction and address adverse member</p>	<p>VillageCareMAX Medicare Total Advantage's conducts internal member satisfaction surveys regularly. VillageCareMAX Medicare</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	VillageCareMAX Medicare Total Advantage's Response	IPRO'S Assessment of VillageCareMAX Medicare Total Advantage's Response
experience with areas linked to quality, timeliness, and access to care.	Total Advantage uses internal and regulatory survey data to develop member experience improvement activities. The customer experience steering committee meets quarterly to discuss the member experience data and improvement activities. Member advisory committee meetings are held quarterly to address member concerns and feedback.	

Performance Improvement Project Summaries and Results

Table 103: VillageCareMAX Medicare Total Advantage's Performance Improvement Project Summary, 2024

VillageCareMAX Medicare Total Advantage 's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By December 2025, VillageCareMAX Medicare Total Advantage aims to increase the percentage of members reporting no depressive feelings from 83.00% to 87.00%. ▪ By December 2025, VillageCareMAX Medicare Total Advantage aims to monitor and track members reporting depressive feelings and had a follow-up positive depression screen through quality metric dashboards. ▪ By December 2025, VillageCareMAX Medicare Total Advantage aims to ensure members with a positive depression screen have a documented intervention within two weeks of completing the Patient Health Questionnaire-9 Screening Tool. ▪ By December 2025, VillageCareMAX Medicare Total Advantage aims to increase the percentage of members who have a follow up within 60 days of a positive depression screening from 20.00% to 75.00%. ▪ By December 2025, VillageCareMAX Medicare Total Advantage aims to increase the percentage of members who have a referral for the behavioral health carved-in benefit within one week of a positive depression screening from 20.00% to 75.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Created electronic dashboards to track Patient Health Questionnaire-9 Screening Tool completion for continuously enrolled members. ▪ Provided trainings to the social work team on available community resources and the integration of www.findhelp.com into guiding care.

VillageCareMAX Medicare Total Advantage 's Performance Improvement Project Summary

- Administer a quarterly post-training competency test to the social work team requiring a passing score of 80.00%.

Member-Focused 2024 Interventions

- Care managers educated members during their monthly calls on the importance of depression screening and the resources available to assist members into care.

Table 104: VillageCareMAX Medicare Total Advantage's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	82.74%	80.25%	87.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	2.66%	7.33%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	20.00%	96.00%	75.00%
Percentage of positive depression screens with follow-up	20.00%	92.00%	75.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	20.00%	73.91%	75.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 105: VillageCareMAX Medicare Total Advantage's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	86%	84%	86%	71%
No Severe Daily Pain	100%	98%	99%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	82%	80%	81%	78%
Pneumococcal Vaccination	81%	80%	83%	83%
COVID-19 Vaccination	Not Available	73%	85%	80%

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 106: VillageCareMAX Medicare Total Advantage’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Table 107: VillageCareMAX Medicare Total Advantage’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
VillageCareMAX failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206

Network Adequacy Results

Table 108: VillageCareMAX Medicare Total Advantage’s Network Gaps, 2024

VillageCareMAX Medicare Total Advantage Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care							1	1								
CORE Family Support and Training				1			2									
CORE Peer Support							1	1								
CORE Psychosocial Rehabilitation				1			1									
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1															
Medically Managed Detox Services					1	2	2	1								
Medically Supervised Detox Services-Outpatient		1			1											
Opioid Treatment Program					3	3	7	1								
Outpatient Mental Health Clinic							1									
Partial Hospitalization						1	1	1								
Personalized Recovery Oriented Services, Continuing Day Treatment								1								
Residential Substance Abuse Treatment Services					1		2	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 109: VillageCareMAX Medicare Total Advantage’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VillageCareMAX Medicare Total Advantage’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	Four of five performance improvement project indicator rates reported by VillageCareMAX Medicare Total Advantage demonstrated improvement between measurement years 2023 and 2024. Two of four performance improvement indicator rates exceeded VillageCareMAX Medicare Total Advantage’s target rates	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for VillageCareMAX Medicare Total Advantage for measurement year 2024 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	VillageCareMAX Medicare Total Advantage met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of five performance improvement project indicator rates reported by VillageCareMAX Medicare Total Advantage demonstrated a decline between measurement years 2023 and 2024. Two of four performance improvement indicators did not reach VillageCareMAX Medicare Total Advantage’s 2024 target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2024 review, VillageCareMAX was not in compliance with one standard of 42 Code Federal Regulations Part 438.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	VillageCareMAX Medicare Total Advantage 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VillageCareMAX Medicare Total Advantage 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	VillageCareMAX Medicare Total Advantage 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, VillageCareMAX Medicare Total Advantage 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	VillageCareMAX Medicare Total Advantage 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 VillageCareMAX Medicare Total Advantage pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	available in the county identified in the Statement of Agreement.			

VNS Health Total

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 110: VNS Health Total’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	VNS Health Total’s Response	IPRO’S Assessment of VNS Health Total’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VNS Health Total 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 Total screens all members for social determinants of health upon enrollment and annually to identify needs, connect members to resources and assess intervention impact. Intervention effectiveness is monitored through annual reassessments and outcome tracking. Collaboration with care management teams and providers reinforces the importance of screening, coding, and resource connections, such as over-the-counter benefits and post hospital home delivered meals, and screening results guide updates to care management tools and resources.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>VNS Health Total 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 Total should focus on enhancing areas of care where its rates are below the Medicaid</p>	<p>VNS Health Total monitors its performance across the quality measures through real-time dashboards. Measure-level goals are established annually and are included in the annual quality workplan. VNS Health Total reviews performance and initiatives in a monthly workgroup and in the quality improvement committee. If performance falls below the statewide average or is not meeting the established goal, VNS Health Total develops and implements specific interventions to address the measure to improve quality of care.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	VNS Health Total's Response	IPRO'S Assessment of VNS Health Total's Response
Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
VNS Health Total 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.	VNS Health Total maintains policies and practices that support compliance with federal Medicaid standards, including provider credentialing, network adequacy, timely access to services, and enrollee assessments. These efforts ensure members receive coordinated, high-quality care aligned with regulatory requirements.	Addressed.
Network Adequacy		
It is recommended that VNS Health Total 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.	The network development team meets weekly to review network adequacy, identify targeted providers, and explore lead generation sources. We will continue to monitor the network for compliance to ensure our members have appropriate access to care. Most deficiencies in the downstate region have been resolved, and we will continue to address any remaining gaps as needed.	Addressed.
Quality-of-Care Survey		
VNS Health Total should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	VNS Health Total administers an interim member satisfaction survey to get additional insights from members on areas that may be underperforming. This survey is administered every year, and VNS Health Total uses the data from it to identify targeted improvement opportunities. Initiatives are designed and implemented to improve member satisfaction and member experience.	Addressed.

Performance Improvement Project Summaries and Results

Table 111: VNS Health Total’s Performance Improvement Project Summary, 2024

VNS Health Total’s Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By the end of 2025, VNS Health Total aims to increase the percentage of continuously enrolled members that report no depressive feelings by six percentage points from 91.00% to 97.00%.▪ By the end of 2025, VNS Health Total aims to increase the percentage of continuously enrolled members that report depressive feelings and had a follow-up positive depression screening by thirty-five percentage points from 0.00% to 35.00%.▪ By the end of 2025, VNS Health Total aims to increase the percentage of continuously enrolled members that have a documented intervention within two weeks of a positive depression screening by sixty-four percentage points from 31.00% to 95.00%.▪ By the end of 2025, VNS Health Total aims to increase the percentage of continuously enrolled members reporting depressive feelings followed by a re-screening for depression within 60 days by seventy percentage points from 0.00% to 70.00%.▪ By the end of 2025, VNS Health Total aims to increase the percentage of continuously enrolled members that were referred for the behavioral health carved-in benefit within one week of a positive depression screening by thirty percentage points from 0.00% to 30.00%.
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Care managers received an initial training on: the workflows for performance indicators, the Patient Health Questionnaire-9 screening assessment, how to accurately assess members for depressive symptoms, and how to identify recommended interventions based off scoring.▪ The care management team received additional educational resources via Healthify and the Knowledge Platform, which aided care managers in providing education and linking members to community resources and services not covered by VNS Health Total.
<p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Collaborated with behavioral health specialists to provide educational events, to engage with members, providing culturally relevant behavioral health literacy in the community.▪ Created provider education shared via Provider E-Newsletters, during on-site meetings, and provider portal updates, addressing the importance of screening for depressive symptoms, as well as highlighting covered and non-covered benefits and resources that address depressive symptoms.
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ VNS Health Total created and published member education highlighting the impact depression may have on their overall health, covered and non-covered benefits, and resources that address and improve depressive symptoms in their Member Newsletter.

VNS Health Total's Performance Improvement Project Summary

- Presented at Member Advisory Council meetings to provide education to members, highlighting the impact depression may have on their overall health and available resources.

Table 112: VNS Health Total's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	90.76%	88.30%	97.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	0.00%	35.00% ¹
Percentage of positive depression screens that have a documented intervention	30.77%	75.00%	95.00%
Percentage of positive depression screens with follow-up	0.00%	8.33%	70.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	0.00%	16.67%	30.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 113: VNS Health Total's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	91%	88%	92%	71%
No Severe Daily Pain	100%	98%	99%	96%
Pain Controlled	98%	98%	99%	98%
Not Lonely and Distressed	100%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	81%	85%	88%	78%
Pneumococcal Vaccination	86%	91%	96%	83%
COVID-19 Vaccination	Not Available	88%	93%	80%

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 114: VNS Health Total’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	NC
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	NC
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Self Disclosure Focused Survey.

Table 115: VNS Health Total’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Provider Network Delivery System Focused Survey		
VNS Health Total failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206
Self Disclosure Focused Survey		
VNS Health Total failed to ensure its enrollees received the right to procedural due process and right to fair hearing by failing to send required notices within the specified timeframes as demonstrated by VNS Health Total’s notification to the Department of Health regarding the self-disclosed system issue between VNS Health Total’s internal system and the VNS Health Total mailing vendor, Command Direct, where 2267 decision letters were never sent to members, as required. This included approvals, extensions, and acknowledgments but also 377 denials where the members did not receive Fair Hearing rights and the initial appeals that were wholly or partially adverse to the enrollee were improperly handled by the Plan and never forwarded for scheduling of a hearing.	Medicaid Advantage Plus Contract Section 25.1-3	438.100, 438.210

Network Adequacy Results

Table 116: VNS Health Total’s Network Gaps, 2024

VNS Health Total Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	2	2		3	1	1	3	2	2	2	2					
Audiology Services	1	1	1	1												
Certified Home Health: Home Based Medical Occupational Therapy						3										
Certified Home Health: Home Based Medical Physical Therapy						3										
Certified Home Health: Home Based Medical Social Services		3														
Certified Home Health: Home Based Medical Speech Therapy						3										
Comprehensive Psychiatric Emergency Program	1	1	1	1												
CORE Community Psychiatric Supports and Treatment	2		2		1		1	2								
CORE Family Support and Training				1	2		2									
CORE Peer Support	3		3	3	1		1	1								
CORE Psychosocial Rehabilitation			1		2		1	2								
Fiscal Intermediary	2	2				1										
Inpatient Mental Health						1										
Institutional Long Term Care					1	1	1	1								
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1								1							
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	1							1							
Institutional Short Term Care					1	1										
Licensed Home Health Care: Home Based Medical Social Services	3		3	3												

VNS Health Total Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Occupational Therapy					3		3	3								
Licensed Home Health Care: Home Based Physical Therapy					3		3	3								
Licensed Home Health Care: Home Based Speech Therapy					3		3	3								
Medically Managed Detox Services		1			1	1	2	2								
Medically Supervised Detox Services - Outpatient	1	1														
Opioid Treatment Program					5	8	10	10								
Oral Surgery	1	1	1	1	1	1	1	2								
Outpatient Mental Health Clinic							1									
Partial Hospitalization					1	2	1	1								
Personalized Recovery Oriented Services, Continuing Day Treatment				1	3	2	1	1						1		
Podiatry	1	1	1	1												
Residential Substance Abuse Treatment Services					1	2	2	2								
Social Day Care					1								2			
Telehealth	3	3	3	3	1	1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 117: VNS Health Total’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VNS Health Total’s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	Three of five performance improvement project indicator rates reported by VNS Health Total demonstrated improvement between measurement years 2023 and 2024.	X	X	X
Performance Measures	Six performance measure rates calculated by the Department of Health for VNS Health Total for measurement year 2024 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 Total met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One performance improvement indicators reported by VNS Health Total demonstrated performance decline between measurement years 2023 and 2024. All five performance improvement project indicators did not reach VNS Health Total’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2024 review activities, VNS was not in compliance with three standards of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	VNS Health Total 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
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	In the ongoing performance improvement project, VNS Health Total 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	VNS Health Total 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 Total 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 Total 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 Total 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

Wellcare Fidelis Dual Plus (HMO D-SNP)

Medicaid Advantage Plus

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, Wellcare Fidelis Dual Plus (HMO D-SNP) operated under the name Fidelis Care.

Table 118: Wellcare Fidelis Dual Plus’s (HMO D-SNP) Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Wellcare Fidelis Dual Plus’s (HMO D-SNP) Response	IPRO’S Assessment of Wellcare Fidelis Dual Plus’s (HMO D-SNP) Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Wellcare Fidelis Dual Plus (HMO D-SNP) 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>Wellcare Fidelis Dual Plus (HMO D-SNP) will continue performance improvement with regular management reports and monthly progress reviews at the long-term care quality committee meetings. Staff and member education materials are provided regularly regarding the performance improvement program both at orientation and annual review. Wellcare Fidelis Dual Plus (HMO D-SNP) will continue to assess members’ social determinants of health needs and provide referrals and interventions to address the needs of those members who score requires assistance with social determinants of health needs.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Wellcare Fidelis Dual Plus (HMO D-SNP) 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</p>	<p>Based on the 2023 New York State Department Of Health performance analysis, Wellcare Fidelis Dual Plus (HMO D-SNP) conducted a root cause assessment to identify improvement opportunities and address key barriers. An action plan was developed and implemented to improve metrics that were noted as significantly below the statewide average. With the action plan in place, Wellcare Fidelis Dual Plus (HMO D-</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Wellcare Fidelis Dual Plus's (HMO D-SNP) Response	IPRO'S Assessment of Wellcare Fidelis Dual Plus's (HMO D-SNP) Response
<p>plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Wellcare Fidelis Dual Plus (HMO D-SNP) should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>SNP) has already seen significant improvement in multiple measures. Ongoing, Wellcare Fidelis Dual Plus (HMO D-SNP) will continue to monitor progress and made adjustments to action plan when needed.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>Wellcare Fidelis Dual Plus (HMO D-SNP) 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>Wellcare Fidelis Dual Plus (HMO D-SNP) has a robust routine monitoring program to ensure compliance with federal and state standards. Wellcare Fidelis Dual Plus (HMO D-SNP) conducts monthly member record reviews using a random sampling of member records. Results of the mock surveys are reported to Fidelis' compliance team for review and monitoring.</p>	<p>Addressed.</p>
<p>Network Adequacy</p>		
<p>It is recommended Wellcare Fidelis Dual Plus (HMO D-SNP) 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.</p>	<p>Wellcare Fidelis Dual Plus (HMO D-SNP) regularly reviews their provider network and works toward a robust provider network in all sixty-two counties served.</p>	<p>Addressed.</p>
<p>Quality-of-Care Survey</p>		
<p>Wellcare Fidelis Dual Plus (HMO D-SNP) should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.</p>	<p>Wellcare Fidelis Dual Plus (HMO D-SNP) conducts member satisfaction surveys by mail and members are encouraged to participate in quarterly member advisory committee meetings where they can offer concerns and suggestions for improvement. This feedback is then shared with the Fidelis quality committee reporting to the Fidelis board.</p>	<p>Addressed.</p>

Performance Improvement Project Summaries and Results

Table 119: Wellcare Fidelis Dual Plus (HMO D-SNP)'s Performance Improvement Project Summary, 2024

Wellcare Fidelis Dual Plus 's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By the end of the final measurement year, Wellcare Fidelis Dual Plus (HMO D-SNP) aims to improve the rate of members who report 'experiencing no depressing feelings' by seven percentage points compared to the baseline measurement year, for continuously enrolled members.▪ By the end of the final measurement year, Wellcare Fidelis Dual Plus (HMO D-SNP) aims to monitor the rate of follow-up positive depression screens using a standardized screening tool and compare the trends with baseline year, for continuously enrolled members who reported depressive feeling on the Uniform Assessment System Community Health Assessment.▪ By the end of the final measurement year, Wellcare Fidelis Dual Plus (HMO D-SNP) aims to increase the rate of members who have a documented intervention within two weeks of a positive depression screening by 70.00%.▪ By the end of the final measurement year, Wellcare Fidelis Dual Plus (HMO D-SNP) aims to increase the frequency of follow-ups conducted by relevant plan personnel within a 60-day timeframe following the initial screening by 70.00%.▪ By the end of the final measurement year, Wellcare Fidelis Dual Plus (HMO D-SNP) aims to increase the rate of referral for the behavioral health carved-in benefit for Medicaid Advantage Plus members within one week of a positive depression screening by 70.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Wellcare Fidelis Dual Plus (HMO D-SNP) developed a computerized system for tracking follow-up and referrals to services and supports.▪ Wellcare Fidelis Dual Plus (HMO D-SNP) refined previous workflows for connecting members to services and supports in a timely manner.▪ Wellcare Fidelis Dual Plus (HMO D-SNP) developed and administered mandatory training for existing/new staff on the newly enhanced workflow. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Wellcare Fidelis Dual Plus (HMO D-SNP) conducted an additional Patient Health Questionnaire-9 screening following the initial follow-up to closely monitor changes in the member's depression status.▪ Wellcare Fidelis Dual Plus (HMO D-SNP) tracked Medicaid Advantage Plus members who declined to opt into behavioral health carved-in services and provided education on the benefits and importance of utilizing available covered services.

Table 120: Wellcare Fidelis Dual Plus (HMO D-SNP)'s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024 ¹	Target
Percentage of members reporting no depressive feelings	68.30%	74.72%	75.30%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	2.40%	9.85%	Target Not Established ²
Percentage of positive depression screens that have a documented intervention	0.00%	100.00%	70.00%
Percentage of positive depression screens with follow-up	0.00%	34.09%	70.00%
Percentage of positive depression screens with a referral for behavioral health carved-in benefit	0.00%	52.17%	70.00%

¹ Indicators 1-4 interim year rates reflect Partial Capitation and Medicaid Advantage Plus lines of business combined.

² Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 121: Wellcare Fidelis Dual Plus (HMO D-SNP)'s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	74%	73%	70%	71%
No Severe Daily Pain	95%	87%	95%	96%
Pain Controlled	97%	96%	97%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	65%	69%	69%	78%
Pneumococcal Vaccination	58%	71%	78%	83%
COVID-19 Vaccination	Not Available	78%	80%	80%

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 122: Wellcare Fidelis Dual Plus (HMO D-SNP)’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2024 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Table 123: Wellcare Fidelis Dual Plus (HMO D-SNP)’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Wellcare Fidelis Dual Plus (HMO D-SNP) failed to meet the minimum requirements for Network Adequacy for required Medicaid Advantage Plus services.	Medicaid Advantage Plus Contract Section 21.1 A.1 Section 21.2 (d)	438.206

Network Adequacy Results

Table 124: Wellcare Fidelis Dual Plus (HMO D-SNP)'s Network Gaps, 2024

Wellcare Fidelis Dual Plus (HMO D-SNP) Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care		1	1	3		1	4	3								
Assertive Community Treatment		6	7			16	13	16								
Assistive Technology Agency and Adaptive Technology		3				3				9				3		
Audiology Services	2	3	4	4		2	1	1								
Certified Home Health					1	5	5	2								
Certified Home Health: Home Based Occupation Therapy					1	5	8	4								
Certified Home Health: Home Based Physical Therapy					1	5	8	4								
Certified Home Health: Home Based Speech Therapy					1	5	8	4								
Community Transitional Service		5				4				6				6		
Comprehensive Psychiatric Emergency Program		1	1	1												
CORE Community Psychiatric Support and Treatment		11	7	10		7	11	6			1					
CORE Family Support and Training		4	15	16		13	4	3							1	2
CORE Peer Support		13	12	15		7	6	4		1	1					2
CORE Psychosocial Rehabilitation		5	11	15		10	4	4								
Environmental Modifications		1				5				1				1		
Fiscal Intermediary		7				1				1						
General Dentistry			1													

Wellcare Fidelis Dual Plus (HMO D-SNP) Network Gaps, 2024

Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Home and Community Support Services		2				1										
Inpatient Chemical Dependency (ASA Inpatient)		1				10	7									
Inpatient Mental Health						5	6	4					1			
Institutional Long Term Care			1		2	3	2	1								
Institutional Long Term Care (AIDS Skilled Nursing Facility)		1	1	1												
Institutional Long Term Care (Vent Skilled Nursing Facility)		3	1			2	2									
Institutional Short Term Care			1		2	4	4	1								
Medically Managed Detox Services					1	4	4	1								
Medically Supervised Detox Services - Inpatient	2	8			1	6	5	3								
Moving Assistance		5				1				6				1		
Opioid Treatment Program		2	1		3	25	9	5								
Optometry	9	11	12	9	2	1	1									
Oral Surgery		5	3	2	2	5	4	2						1		1
Outpatient Chemical Dependency - Clinic					3	2	1	1								
Outpatient Chemical Dependency - Outpatient Rehabilitation				2		1										
Outpatient Mental Health Clinic					4	7	5									
Partial Hospitalization	3	7	5	5	3	17	11	5					7	1	1	
Personalized Recovery Oriented Services, Continuing Day Treatment		4	3			2	4	1		2	1			6	1	
Podiatry	1	2	1	2		1	1	1								
Residential Substance Abuse Treatment Services		13	4	2		7	5	4								
Social Day Care	1	2	3	1	3	5	6	3	2	4	6		2	5	6	5

Wellcare Fidelis Dual Plus (HMO D-SNP) Network Gaps, 2024

Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Telehealth		10	10	4		3	3	2								
Therapy: Occupational		3	5	1												
Therapy: Physical		1	1				1									
Therapy: Respiratory	3	3														
Therapy: Speech and Language	1	4	6	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 125: Wellcare Fidelis Dual Plus (HMO D-SNP)'s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Wellcare Fidelis Dual Plus (HMO D-SNP)'s performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2024.			
	All performance improvement project indicator rates reported by Wellcare Fidelis Dual Plus (HMO D-SNP) demonstrated improvement between measurement years 2023 and 2024. One of four performance improvement project indicator rates exceeded Wellcare Fidelis Dual Plus (HMO D-SNP)'s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Wellcare Fidelis Dual Plus (HMO D-SNP) met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Three of four performance improvement indicator rates did not reach Wellcare Fidelis Dual Plus (HMO D-SNP)'s target rates.	X	X	X
Performance Measures	One performance measure rates calculated by the Department of Health for Wellcare Fidelis Dual Plus (HMO D-SNP) for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review, Wellcare Fidelis Dual Plus (HMO D-SNP) was not in compliance with one standard of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	Wellcare Fidelis Dual Plus (HMO D-SNP) has the opportunity to reduce their gaps in their network that were identified in their Statement of Agreement when the provider type(s) is		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	available in the county identified in the Statement of Agreement.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Wellcare Fidelis Dual Plus (HMO D-SNP) 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	Wellcare Fidelis Dual Plus (HMO D-SNP) 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, Wellcare Fidelis Dual Plus (HMO D-SNP) 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	Wellcare Fidelis Dual Plus (HMO D-SNP) 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 Wellcare Fidelis Dual Plus (HMO D-SNP) 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

Aetna Better Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 126: Aetna Better Health’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Aetna Better Health’s Response	IPRO’S Assessment of Aetna Better Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Aetna Better 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>Aetna Better Health continuously monitors performance improvement project progress through data analysis, stakeholder input, and regular reporting. High-impact interventions are sustained and expanded, while low-impact ones are revised or retired based on barrier analysis and outcome trends. New initiatives are piloted as needed. Effectiveness is tracked via dashboards, quarterly reviews, and feedback from care teams and members to ensure ongoing improvement.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Aetna Better 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, Aetna Better Health should focus on enhancing areas of care where its rates are below the</p>	<p>Aetna Better Health leverages Department of Health data and internal analytics to identify and address areas below the Medicaid Managed Long-Term Care mean. Interventions include targeted outreach, staff training, and process enhancements. Monthly performance reviews, member education, and care gap closure strategies are implemented. Progress is tracked using dashboards to identify issues, and results are shared with leadership for continuous quality improvement.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Aetna Better Health's Response	IPRO'S Assessment of Aetna Better Health's Response
Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
<p>Aetna Better Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Aetna Better Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>Aetna Better Health maintains a robust compliance program, conducting regular internal audits, staff training, and corrective action plans to address findings. The annual compliance plan is updated to reflect any new requirements and review external feedback. Ongoing monitoring, policy updates, and readiness assessments ensure alignment with federal and state standards, and preparation for Department of Health reviews. Effectiveness is evaluated through the result of the audits.</p>	<p>Addressed.</p>
Network Adequacy		
<p>It is recommended that Aetna Better 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.</p>	<p>Aetna Better Health actively pursues provider contracts to address network gaps, focusing on counties and provider types identified in the statement of agreement. Recruitment strategies include outreach to new providers, collaboration with provider relations, and incentives for participation. Network adequacy is reviewed quarterly, and progress is reported to leadership. Efforts aim to improve member access, choice, and compliance with regulatory standards.</p>	<p>Addressed.</p>
Quality-of-Care Survey		
<p>Aetna Better Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.</p>	<p>Aetna Better Health reviews member satisfaction survey data and analyzes the results to identify areas for improvement in quality, timeliness, and access to care. Action plans are developed to address adverse member</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Aetna Better Health's Response	IPRO'S Assessment of Aetna Better Health's Response
	experiences, including targeted interventions, staff retraining, process improvements and any necessary follow-up. Results are reviewed by leadership and quality committees to drive ongoing enhancements in member experience.	

Performance Improvement Project Summaries and Results

Table 127: Aetna Better Health's Performance Improvement Project Summary, 2024

Aetna Better Health's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of 2025, Aetna Better Health aims to increase the percentage of members reporting no depressive feelings by five percentage points compared to the baseline year for managed long-term care community-based continuously enrolled members assessed via the Uniform Assessment System Community Health Assessment. ▪ By the end of 2025, Aetna Better Health aims to monitor and trend the percentage of members reporting depressive feelings and had a follow-up positive depression screen compared to the baseline year for managed long-term care community-based continuously enrolled members assessed that reported depressive feelings on the Uniform Assessment System Community Health Assessment. ▪ By the end of 2025, Aetna Better Health aims to increase the percentage of members with a documented intervention within two weeks of a positive depression screening by 50.00%. ▪ By the end of 2025, Aetna Better Health aims to increase the percentage of members with follow-up within 60 days after a positive depression screening by 50.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Aetna Better Health's analytics team generated daily reports identifying all members with completed Uniform Assessment System Community Health Assessments. ▪ Aetna Better Health's analytics team created a monthly report to guide care managers with member follow-up after Patient Health Questionnaire-9 screening. ▪ To aid in the referral process, care management staff utilized the Community Resource Directory: a database full of local social and behavioral health services. ▪ Care managers opened activity tracking events within the electronic medical record to capture rescreens if clinically indicated, referral status and compliance with treatment.

Aetna Better Health’s Performance Improvement Project Summary

- Care management staff completed mandatory web-based Relias Training: “Depression and Suicidality in Older Adults” and implemented a competency assessment for staff members based on the training material.

Member-Focused 2024 Interventions

- Care management staff conducted telephonic outreach to provide member education on depression by using the member teach-back technique.

Table 128: Aetna Better Health’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	92.37%	93.22%	97.37%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.69%	15.13%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	0.00%	57.14%	50.00%
Percentage of positive depression screens with follow-up	0.00%	76.19%	50.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 129: Aetna Better Health’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	87%	86%	89%	71%
No Severe Daily Pain	97%	98%	98%	96%
Pain Controlled	97%	98%	99%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	81%	82%	80%	78%
Pneumococcal Vaccination	82%	83%	81%	83%
COVID-19 Vaccination	Not Available	83%	83%	80%

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 130: Aetna Better Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 131: Aetna Better Health’s Network Gaps, 2024

Aetna Better Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1		1		2		2	1								
Audiology Services			2	2			1									
Certified Home Health					1		1	1								
Certified Home Health: Home Based Medical Social Services					2		3	2								
Certified Home Health: Home Based Occupational Therapy					1		2	1								
Certified Home Health: Home Based Physical Therapy					1		2	1								
Certified Home Health: Home Based Speech Therapy					1		2	1								
Consumer Directed Personal Care			2				4	1								
Fiscal Intermediary	1				1		4	1								
Home Delivered and Congregate Meals	1		1		4		5									
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	2	2	1	1	1	2	2								
Institutional Long Term Care (Vent Skilled Nursing Facility)			1	1	1		1									
Institutional Short Term Care	5		4			1	2									
Licensed Home Health Care: Home Based Medical Social Services			4	2			1									
Licensed Home Health Care: Home Based Speech Therapy			5				1									
Private Duty Nursing	1		5	2	3		1	2								
Social Day Care					1		1									
Social and Environmental Support							1									

Aetna Better Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Telehealth	5		6													
Therapy: Occupational	1		2	2			2									
Therapy: Physical							1									
Therapy: Respiratory	5		6	1				1								
Therapy: Speech and Language	1		4	1	1		1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 132: Aetna Better Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Aetna Better Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Three of four performance improvement project indicator rates reported by Aetna Better Health demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of four performance improvement indicator rates exceeded Aetna Better Health’s target rate.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Aetna Better Health for measurement year 2024 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 Better Health met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Aetna Better Health did not reach the target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Aetna Better 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

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Aetna Better 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	Aetna Better 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, Aetna Better 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	Aetna Better 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 that Aetna Better 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

Anthem Blue Cross and Blue Shield HP MLTC

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, Anthem Blue Cross and Blue Shield HP MLTC operated under the name Empire BCBS HealthPlus.

Table 133: Anthem Blue Cross and Blue Shield HP MLTC’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Anthem Blue Cross and Blue Shield HP MLTC’s Response	IPRO’S Assessment of Anthem Blue Cross and Blue Shield HP MLTC’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Anthem Blue Cross and Blue Shield HP MLTC 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>Anthem Blue Cross and Blue Shield HP MLTC continues to monitor these performance indicators and has developed and implemented new workflows to engage with the regional social care network lead entities who are responsible for screening referred Anthem Blue Cross and Blue Shield HP MLTC members, and providing navigation support to health-related social needs services within their region based on the member's needs. Anthem Blue Cross and Blue Shield HP MLTC will track metrics related to health-related social needs screening, referrals, and utilization of community resources and analyze data to identify trends and areas for improvement.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Anthem Blue Cross and Blue Shield HP MLTC 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</p>	<p>Anthem Blue Cross and Blue Shield HP MLTC continuously uses data from the annual Managed Long-Term Care report to ensure our quality assurance/performance improvement program addresses all quality performance domains. By analyzing Anthem Blue Cross and Blue Shield HP MLTC-specific and statewide results, we</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Anthem Blue Cross and Blue Shield HP MLTC's Response	IPRO'S Assessment of Anthem Blue Cross and Blue Shield HP MLTC's Response
<p>members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Anthem Blue Cross and Blue Shield HP MLTC should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>determine whether our performance is above, equal to, or below the statewide average. This analysis forms the basis for data-driven improvement initiatives to enhance areas of care where rates fall below the mean, and guide efforts to elevate the Anthem Blue Cross and Blue Shield HP MLTC 's overall performance in the delivery of top-quality care.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>Anthem Blue Cross and Blue Shield HP MLTC 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>To ensure readiness for the Department of Health's compliance review, Anthem Blue Cross Blue Shield HP MLTC conducts thorough internal assessments to proactively identify and address any potential issues. Updates and findings from these activities are consistently shared with the quality management committee, maintaining transparency and accountability.</p>	<p>Addressed.</p>
<p>Network Adequacy</p>		
<p>It is recommended Anthem Blue Cross and Blue Shield HP MLTC 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.</p>	<p>Anthem Blue Cross and Blue Shield HP MLTC has an established, robust network and will continue to enhance it to ensure all standards are met and members have access to care.</p>	<p>Partially Addressed.</p>
<p>Quality-of-Care Survey</p>		
<p>Despite its small sample size for the member satisfaction survey, Anthem Blue Cross and Blue Shield HP MLTC should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.</p>	<p>Anthem Blue Cross and Blue Shield HP MLTC actively utilizes data from internal member satisfaction survey to assess how our members rate their satisfaction with providers and services. By evaluating Anthem Blue Cross and Blue Shield HP MLTC's performance, we develop data-</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Anthem Blue Cross and Blue Shield HP MLTC's Response	IPRO'S Assessment of Anthem Blue Cross and Blue Shield HP MLTC's Response
	driven initiatives to enhance member satisfaction, focusing on improving adverse experiences related to quality, timeliness, and access to care with the goal of continuously improving and ultimately delivering top-quality services to our members.	

Performance Improvement Project Summaries and Results

Table 134: Anthem Blue Cross and Blue Shield HP MLTC's Performance Improvement Project Summary, 2024

Anthem Blue Cross and Blue Shield HP MLTC's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of the final reporting year, Anthem Blue Cross and Blue Shield HP MLTC aims to improve the rate of members reporting no depressive feelings on the Community Health Assessment from 74.48% to 80.00%. ▪ By the end of the final reporting year, Anthem Blue Cross and Blue Shield HP MLTC aims to increase the rate of documented interventions for members screening positive (scores of five or more on the Patient Health Questionnaire-9) from 25.00% to 69.50%. ▪ By the end of the final reporting year, Anthem Blue Cross and Blue Shield HP MLTC aims to increase the percentage of members with follow up after a positive depression screening from 6.25% to 60.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Implemented the Patient Health Questionnaire-9 tool to screen members who identified depressive feelings within the Uniform Assessment System Community Health Assessment. ▪ Created and implemented a standardized workflow to ensure that members who score five or more on the Patient Health Questionnaire-9 screening tool have appropriate follow-up. ▪ Staff received training on strategies to enhance members' comfort in discussing their mood and building trust with mental health providers.

Table 135: Anthem Blue Cross and Blue Shield HP MLTC’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	74.83%	78.00%	80.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.61%	8.82%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	25.00%	8.26%	69.50%
Percentage of positive depression screens with follow-up	6.25%	5.93%	60.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 136: Anthem Blue Cross and Blue Shield HP MLTC’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	88%	74%	82%	71%
No Severe Daily Pain	100%	100%	100%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	100%	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	78%	83%	84%	78%
Pneumococcal Vaccination	81%	82%	85%	83%
COVID-19 Vaccination	Not Available	84%	85%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 137: Anthem Blue Cross and Blue Shield HP MLTC’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2022 Focused ²	2022 Focused ³	2023 Focused ⁴	2024 Comprehensive
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	NC
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.206: Availability of Services	Not Reviewed	Not Reviewed	Not Reviewed	C	C
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	NC	Not Reviewed	C
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.228: Grievance and Appeal System	C	Not Reviewed	Not Reviewed	Not Reviewed	NC
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	C

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.

¹ Appeals and Fair Hearing Focused Survey.

² Member Services Focused Survey. Areas surveyed were outside of Title 42 Code of Federal Regulations 438 requirements.

³ Complaint Investigation Focused Survey.

⁴ Provider Network Delivery System Focused Survey.

Table 138: Anthem Blue Cross and Blue Shield HP MLTC’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Six records submitted for review lacked evidence of monthly care management contact or documented attempts.	Partial Capitation Contract Article V J. 6. a	438.100
Forty-one records submitted for review lacked evidence of a 6-month care management home visit.	Partial Capitation Contract Article V J. 6. b	438.100
Two records submitted for review did not contain evidence of acknowledgement and/or determination notices for complaints that could not be resolved immediately.	Partial Capitation Contract Appendix K 1. A	438.100
For five initial adverse determination notices, the Plan failed to provide the enrollee with the denial reason; reason erroneously given was “the other decision”.	Partial Capitation Contract Appendix K	438.228
For one appeal, no evidence was provided that the determination was sent within the required timeframe.	Partial Capitation Contract Appendix K	438.228

Network Adequacy Results

Table 139: Anthem Blue Cross and Blue Shield HP MLTC’s Network Gaps, 2024

Anthem Blue Cross and Blue Shield HP MLTC Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care							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.

Strengths, Opportunities for Improvement, and Recommendations

Table 140: Anthem Blue Cross and Blue Shield HP MLTC’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Anthem Blus Cross and Blue Shield HP MLTC’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Two of four performance improvement project indicator rates reported by Anthem Blus Cross and Blue Shield HP MLTC demonstrated improvement and one was maintained between measurement years 2023 and 2024.	X	X	X
Performance Measures	All seven performance measure rates calculated by the Department of Health for Anthem Blus Cross and Blue Shield HP MLTC for measurement year 2024 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review, Anthem Blus Cross and Blue Shield HP MLTC was in compliance with twelve standards of 42 Code of Federal Regulations Part 438	X	X	X
Network Adequacy	Anthem Blus Cross and Blue Shield HP MLTC met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by Anthem Blus Cross and Blue Shield HP MLTC demonstrated a decline between measurement years 2023 and 2024. None of the performance improvement indicator rates reached Anthem Blus Cross and Blue Shield HP MLTC’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2024 review, Anthem Blus Cross and Blue Shield HP MLTC was not in full compliance with two standards of 42 Code of Federal Regulations Part 438.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Anthem Blus Cross and Blue Sheild HP MLTC 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Anthem Blue Cross and Blue Sheild HP MLTC 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	Anthem Blus Cross and Blue Sheild HP MLTC 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, Anthem Blus Cross and Blue Sheild HP MLTC 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	Anthem Blus Cross and Blue Sheild HP MLTC should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. Anthem Blus Cross and Blue Sheild HP MLTC 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 Anthem Blus Cross and Blue Sheild HP MLTC pursue provider contracts to		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	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.			

Archcare

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Archcare was acquired by VillageCareMAX effective 06/01/2024.

Performance Improvement Project Summaries and Results

Archcare was acquired by VillageCareMAX effective 06/01/2024.

Performance Measure Results

Archcare was acquired by VillageCareMAX effective 06/01/2024.

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

Table 141: Archcare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 142: Archcare’s Network Gaps, 2024

Archcare Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care		7														
Audiology Services		3				1										
Certified Home Health		2				1										
Certified Home Health: Home Based Medical Social Services		2				1										
Certified Home Health: Home Based Occupational Therapy		2				1										
Certified Home Health: Home Based Physical Therapy		2				1										
Certified Home Health: Home Based Speech Therapy		2				1										
Certified or Licensed Home Health Care - Personal Care Assistant		2				1										
Durable Medical Equipment		6				1										
Fiscal Intermediary		7														
Home Delivered and Congregate Meals		7			1											
Institutional Long Term Care		7														
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	4			1				1							
Institutional Long Term Care (Vent Skilled Nursing Facility)		5			1				1							
Institutional Short Term Care		7														
Licensed Home Health Care		7														
Licensed Home Health Care: Home Based Medical Social Services		7														

Archcare Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Occupational Therapy		7														
Licensed Home Health Care: Home Based Physical Therapy		7														
Licensed Home Health Care: Home Based Speech Therapy		7														
Non-Emergent Transportation	1				2											
Nutrition		2														
Optometry	1	3				3										
Oral Surgery	1	1														
Personal Emergency Response		7														
Podiatry					1	1										
Private Duty Nursing		7														
Social Day Care		2				2										
Social and Environmental Support		7														
Telehealth		7														
Therapy: Occupational		7														
Therapy: Physical		2				1										
Therapy: Respiratory		7														
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.

Strengths, Opportunities for Improvement, and Recommendations

Archcare was acquired by VillageCareMAX effective 06/01/2024.

Centers Plan for Healthy Living

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 143: Centers Plan for Health Living’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Centers Plan for Health Living’s Response	IPRO’S Assessment of Centers Plan for Health Living’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Centers Plan for Health Living 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 for Healthy Living's 2023 performance improvement project on the social determinants of health was successful, as we met and exceeded all goals of providing screening and follow-up interventions for members with a positive screening. We successfully implemented the screening in our care management system and provided our staff with education and resources. We continue to conduct screenings and monitor results to identify areas of improvement. The social determinants of health screening and follow-up has had a positive impact on the health outcomes of our members.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Centers Plan for Healthy Living 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 for Healthy Living should focus on enhancing areas</p>	<p>Centers Plan for Healthy Living did not meet the statewide average for three measures in 2023, including no shortness of breath, no severe daily pain, and COVID-19 vaccination. To address these gaps, our care management team focused on providing improved disease management, education, and coordination of care. We implemented a teach-back strategy to identify the effectiveness of our training and education. We continuously monitor our member outcomes</p>	<p>Addressed</p>

2023 External Quality Review Recommendation	Centers Plan for Health Living's Response	IPRO'S Assessment of Centers Plan for Health Living's Response
of care where their rates are below the Medicaid Managed Long-term Care program mean.	and collaborate to identify improvement strategies.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Centers Plan for Healthy Living 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 for Healthy Living should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	As stated in the 2023 report, there were no survey results. In the 2021 survey, 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 Centers Plan for Healthy Living's historical processes that had been addressed prior to the survey findings. To ensure ongoing compliance, Centers Plan for Healthy Living has executed the state-approved plan of correction and continues to conduct routine monitoring to ensure compliance is achieved and maintained.	Partially Addressed.
Network Adequacy		
It is recommended Centers Plan for Healthy Living 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.	Centers Plan for Healthy Living actively pursues contracts to address identified network gaps. Centers Plan for Healthy Living continues to work to overcome identified challenges to addressing these gaps that include providers that are unwilling to contract, fail credentialing, are unavailable, or do not maintain good faith negotiations.	Addressed.
Quality-of-Care Survey		
Centers Plan for Healthy Living should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Centers Plan for Healthy Living had no values significantly below the statewide average for evaluation, quality of care, access to care, or timeliness of care measures on the 2023 Member Satisfaction Survey. We evaluate results of the survey and continue to focus efforts on improving member experience and health outcome measures. We also	Addressed.

2023 External Quality Review Recommendation	Centers Plan for Health Living's Response	IPRO'S Assessment of Centers Plan for Health Living's Response
	conduct an annual internal member satisfaction survey to identify areas in need of improvement and better understand our members needs and desires.	

Performance Improvement Project Summaries and Results

Table 144: Centers Plan for Healthy Living's Performance Improvement Project Summary, 2024

Centers Plan for Healthy Living's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ Centers Plan for Healthy Living aims to increase members reporting no depressive feelings based on the Uniform Assessment System Community Health Assessment self-reported mood question by three percentage points from the baseline in 2024, and by an additional three percentage points from the 2024 results in 2025. ▪ Centers Plan for Healthy Living aims to monitor members reporting depressive feelings who have also had a follow-up positive depression screening to ensure appropriate follow-up. ▪ Centers Plan for Healthy Living aims to increase the percentage of members with a documented intervention within two weeks of a positive depression screening by 1.00% from the baseline measurement year to the final measurement year. ▪ Centers Plan for Healthy Living aims to increase the rate of follow up within 60 days for members with a positive depression screening to 75.00% in 2024 and to 80.00% in 2025. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Centers Plan for Healthy Living provided cultural competency training to all staff annually, as well as on initial hire to increase cultural awareness, knowledge, and skills. ▪ Centers Plan for Healthy Living care managers received comprehensive training on depression screening and follow-up including: member resources and education on depression, medication management, and community services for members with a positive screening. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Centers Plan for Healthy Living assigned care management staff to members based on spoken language to bridge gaps in communication by explaining health-related information in a way members can understand. ▪ Care managers provided members with resources and education on depression, medication management, and applicable community services upon an identified positive screening.

Table 145: Centers Plan for Healthy Living’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	55.62%	56.30%	61.62%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	13.44%	27.18%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	97.46%	99.73%	98.46%
Percentage of positive depression screens with follow-up	Not Available	96.89%	80.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 146: Centers Plan for Healthy Living’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	49%	46%	45%	71%
No Severe Daily Pain	87%	86%	85%	96%
Pain Controlled	98%	99%	99%	98%
Not Lonely and Distressed	99%	99%	100%	99%
Effectiveness of Care				
Influenza Vaccination	78%	79%	78%	78%
Pneumococcal Vaccination	86%	88%	88%	83%
COVID-19 Vaccination	Not Available	52%	59%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 147: Centers Plan for Healthy Living’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 148: Centers Plan for Healthy Living’s Network Gaps, 2024

Centers Plan for Healthy Living Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care					1	1	2	1								
Institutional Long Term Care (AIDS Skilled Nursing Facility)	1	1		1			1		1							
Institutional Long Term Care (Vent Skilled Nursing Facility)						1	1	1	1							
Oral Surgery	1	1		1			1									
Therapy: Respiratory									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.

Strengths, Opportunities for Improvement, and Recommendations

Table 149: Centers Plan for Healthy Living’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Centers Plan for Healthy Living’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024			
	Two of three performance improvement project indicator rates reported by Centers Plan for Healthy Living demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of three performance improvement project indicator rates exceeded Centers Plan for Healthy Living’s target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Centers Plan for Healthy Living for measurement year 2024 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 for Healthy Living met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of three performance improvement project indicator rates reported by Centers Plan for Healthy Living did not meet the target goal.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Centers Plan for Healthy Living for measurement year 2024 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	Centers Plan for Healthy Living 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Centers Plan for Healthy Living 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 for Healthy Living 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 for Healthy Living 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 for Healthy Living 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 Centers Plan for Healthy Living pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	county identified in the Statement of Agreement.			

Elderwood Health Plan

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Elderwood Health Plan was acquired by VNS Health Choice effective 05/01/2024.

Performance Improvement Project Summaries and Results

Elderwood Health Plan was acquired by VNS Health Choice effective 05/01/2024.

Performance Measure Results

Elderwood Health Plan was acquired by VNS Health Choice effective 05/01/2024.

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

Table 150: Elderwood Health Plan’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Comprehensive	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	C	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	C	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	C	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	NC	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	NC	Not Reviewed
438.214: Provider Selection	Not Reviewed	C	Not Reviewed
438.224: Confidentiality	Not Reviewed	C	Not Reviewed
438.228: Grievance and Appeal System	C	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	C	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	C	Not Reviewed
438.242: Health Information Systems	Not Reviewed	NC	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	C	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 151: Elderwood Health Plan’s Network Gaps, 2024

Elderwood Health Plan Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Audiology Services	1															
General Dentistry					1											
Institutional Long Term Care (Vent Skilled Nursing Facility)													1			
Optometry	1	2				1										
Oral Surgery	1															
Podiatry					3											
Social Day Care		1			2	1										
Telehealth	4	1							2							
Therapy: Occupational	1															
Therapy: Physical	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.

Strengths, Opportunities for Improvement, and Recommendations

Elderwood Health Plan was acquired by VNS Health Choice effective 05/01/2024.

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

EverCare was acquired by HomeFirst effective 05/01/2024.

Performance Improvement Project Summaries and Results

EverCare was acquired by HomeFirst effective 05/01/2024.

Performance Measure Results

EverCare was acquired by HomeFirst effective 05/01/2024.

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

Table 152: EverCare’s Compliance with Federal Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Comprehensive	2022 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	C	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	NC	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	C	Not Reviewed	Not Reviewed
438.206: Availability of Services	C	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	C	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	NC	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	NC	Not Reviewed	Not Reviewed
438.214: Provider Selection	C	Not Reviewed	Not Reviewed
438.224: Confidentiality	C	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	NC	Not Reviewed
438.230: Subcontractual Relationships and Delegation	C	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	C	Not Reviewed	Not Reviewed
438.242: Health Information Systems	NC	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	C	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 153: EverCare Network Gaps, 2024

EverCare Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care		1														
Licensed Home Health Care: Home Based Occupational Therapy		3														
Licensed Home Health Care: Home Based Physical Therapy		1				2										
Licensed Home Health Care: Home Based Speech Therapy		3														
Optometry	1	2														
Oral Surgery	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.

Strengths, Opportunities for Improvement, and Recommendations

EverCare was acquired by HomeFirst effective 05/01/2024.

Extended MLTC

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Extended MLTC ceased operations within measurement year 2023. Extended MLTC was acquired by Hamaspik Choice on 08/01/2023.

Performance Improvement Project Summaries and Results

Extended MLTC ceased operations within measurement year 2023. Extended MLTC was acquired by Hamaspik Choice on 08/01/2023.

Performance Measure Results

Extended MLTC ceased operations within measurement year 2023. Extended MLTC was acquired by Hamaspik Choice on 08/01/2023.

Compliance with Medicaid and Children's Health Insurance Program

Standards Results

Table 154: Extended MLTC's Compliance with Federal Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Extended MLTC ceased operations within measurement year 2023. Extended MLTC was acquired by Hamaspik Choice on 08/01/2023.

Strengths, Opportunities for Improvement, and Recommendations

Extended MLTC ceased operations within measurement year 2023. Extended MLTC was acquired by Hamaspik Choice on 08/01/2023.

Fallon Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Fallon Health announced a withdrawal effective 01/01/2024.

Performance Improvement Project Summaries and Results

Fallon Health announced a withdrawal effective 01/01/2024.

Performance Measure Results

Fallon Health announced a withdrawal effective 01/01/2024.

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

Table 155: Fallon Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Comprehensive	2022 Focused ¹	2023 Focused ²	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	C	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	C	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	C	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	NC	Not Reviewed	C	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	C	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	C	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	C	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	C	Not Reviewed	Not Reviewed	NC
438.236: Practice Guidelines	C	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	NC	Not Reviewed	Not Reviewed	Not Reviewed

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Comprehensive	2022 Focused ¹	2023 Focused ²	2024 Focused ³
438.330: Quality Assessment and Performance Improvement Program	C	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Management Services Agreement Focused Survey.

Table 156: Fallon Health’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Fallon 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.	Partial Capitation Contract Article VII B. Part 98 of New York Codes, Rules, and Regulations Section 98-1.11 (k)	438.230

Network Adequacy Results

Fallon Health announced a withdrawal effective 01/01/2024.

Strengths, Opportunities for Improvement, and Recommendations

Fallon Health announced a withdrawal effective 01/01/2024.

Fidelis Care at Home

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 157: Fidelis Care at Home’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Fidelis Care at Home’s Response	IPRO’S Assessment of Fidelis Care at Home’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Fidelis Care at Home 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 at Home will continue performance improvement with regular management reports and monthly progress reviews at the long-term care quality committee meetings. Staff and member education materials are provided regularly regarding the performance improvement program both at orientation and annual review. Fidelis Care at Home will continue to assess members social determinants of health needs and provide referrals and interventions to address the needs of those members who score requires assistance with social determinants of health needs.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Fidelis Care at Home 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 at Home should</p>	<p>Based on the 2023 New York State Department Of Health performance analysis, Fidelis Care at Home conducted a root cause assessment to identify improvement opportunities and address key barriers. An action plan was developed and implemented to improve metrics that were noted as significantly below the statewide average. With the action plan in place, Fidelis Care at Home has already seen significant improvement in multiple measures. Ongoing,</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Fidelis Care at Home's Response	IPRO'S Assessment of Fidelis Care at Home's Response
focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	Fidelis Care at Home will continue to monitor progress and made adjustments to action plan when needed.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Fidelis Care at Home 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 Care at Home has a robust routine monitoring program to ensure the compliance with federal and state standards. Fidelis Care at Home conducts monthly member record reviews using a randomized sampling of member records. Results of the mock surveys are reported to Fidelis Care at Home for review and monitoring.	Addressed.
Network Adequacy		
It is recommended Fidelis Care at Home 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.	Fidelis Care at Home regularly reviews their provider network and works toward a robust provider network in all 62 counties served.	Addressed.
Quality-of-Care Survey		
Fidelis Care at Home should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Fidelis Care at Home conducts periodic member satisfaction surveys by mail. Members are also encouraged to participate in the quarterly member advisory committee meetings to share their concerns and suggestions regarding the Fidelis Care at Home's quality of care, timeliness and access to care. Concerns and suggestions are shared at the Fidelis Care at Home's quality committee board meetings.	Addressed.

Performance Improvement Project Summaries and Results

Table 158: Fidelis Care at Home’s Performance Improvement Project Summary, 2024

Fidelis Care at Home’s Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
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
<u>Aims</u>
<ul style="list-style-type: none">▪ By the end of the final measurement year, Fidelis Care at Home aims to improve the rate of members who report ‘experiencing no depressing feelings’ by seven percentage points compared to the baseline measurement year, for continuously enrolled members.▪ By the end of the final measurement year, Fidelis Care at Home aims to monitor the rate of follow-up positive depression screens using a standardized screening tool for continuously enrolled members who reported depressive feelings on the Uniform Assessment System Community Health Assessment.▪ By the end of the final measurement year, Fidelis Care at Home aims to increase the percentage of continuously enrolled members who receive a documented intervention within two weeks of a positive depression screening (using a standardized screening tool) by 70.00%.▪ By the end of the final measurement year, Fidelis Care at Home aims to increase the percentage of continuously enrolled members who receive a follow up within 60 days of a positive depression screening (using a standardized screening tool) by 70.00%.
<u>Managed Care Plan-Focused 2024 Interventions</u>
<ul style="list-style-type: none">▪ Fidelis Care at Home developed a computerized system for tracking follow-ups and referrals to services and supports.▪ Fidelis Care at Home refined previous workflows for connecting members to services and supports in a timely manner.▪ Fidelis Care at Home developed and administered mandatory training for existing/new staff on the newly enhanced workflow.
<u>Member-Focused 2024 Interventions</u>
<ul style="list-style-type: none">▪ Fidelis Care at Home conducted an additional Patient Health Questionnaire-9 screening following the initial follow-up to closely monitor changes in the member's depression status.

Table 159: Fidelis Care at Home’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024 ¹	Target
Percentage of members reporting no depressive feelings	68.30%	74.72%	75.30%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	2.40%	9.85%	Target Not Established ²
Percentage of positive depression screens that have a documented intervention	0.00%	100.00%	70.00%
Percentage of positive depression screens with follow-up	0.00%	34.09%	70.00%

¹ Interim year rates reflect Partially Capitated and Medicaid Advantage Plus lines of business combined.

² Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 160: Fidelis Care at Home’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	76%	73%	70%	71%
No Severe Daily Pain	92%	92%	94%	96%
Pain Controlled	97%	97%	96%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	67%	66%	67%	78%
Pneumococcal Vaccination	65%	66%	75%	83%
COVID-19 Vaccination	Not Available	75%	79%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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: Fidelis Care at Home’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 162: Fidelis Care at Home’s Network Gaps, 2024

Fidelis Care at Home Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care		1	1	2	2	2	9	9								
Assistive Technology Agency and Adaptive Technology		1				4				12				4		
Audiology Services	1	2	4	5		3	3	1								
Certified Home Health			1			4	5	5								
Certified Home Health: Home Based Occupational Therapy			1			4	8	5								
Certified Home Health: Home Based Physical Therapy			1			4	8	5								
Certified Home Health: Home Based Speech Therapy			1			4	8	5								
Community Transitional Service		3				1				7				2		
Environmental Modifications		3				5				3				10		
Fiscal Intermediary					1					1						
General Dentistry			2	1				1								
Institutional Long Term Care			1		3	4	5	3								
Institutional Long Term Care (AIDS Skilled Nursing Facility)		1	1	1												
Institutional Long Term Care (Vent Skilled Nursing Facility)			2	1	1	1	2	1								
Institutional Short Term Care			1		3	4	9	3								
Moving Assistance		5				2				16				2		
Optometry	9	7	10	9		1										
Oral Surgery		2	6	8	2	1	2	2	1	1						
Podiatry		2	3	10		5	4	7								
Social Day Care	4	7	12	23	3	12	8	4	3	1	7			1	4	

Fidelis Care at Home Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Telehealth	3	1	7	7			7	7			2				1	
Therapy: Occupational		4	9	7		1										
Therapy: Physical				1			1									
Therapy: Respiratory		6							1							
Therapy: Speech and Language	1	5	10	9	2	2	4	1								
Vehicle Modification										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.

Strengths, Opportunities for Improvement, and Recommendations

Table 163: Fidelis Care at Home’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care at Home’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	All four performance improvement project indicator rates reported by Fidelis Care at Home demonstrated improvement between measurement years 2023 and 2024. One of three performance improvement project indicator rates exceeded Fidelis Care at Home’s target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Fidelis Care at Home met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Two of three performance improvement project indicator rates reported by Fidelis Care at Home did not meet the target goal.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Fidelis Care at Home for measurement year 2024 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 at Home 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

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fidelis Care at Home 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	Fidelis Care at Home 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 at Home 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 at Home 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 at Home 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

Hamaspik Choice

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 164: Hamaspik Choice’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Hamaspik Choice’s Response	IPRO’S Assessment of Hamaspik Choice’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Hamaspik Choice 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>Now fully available and integrated into the community, Hamaspik Choice utilizes social care networks as a resource for our members to support their social determinants of health needs. Hamaspik Choice assists members in connecting to their county’s social care networks for assessment, as needed. Internal resources are also maintained for staff and members, and interventions can be implemented and carried out, as needed.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Hamaspik Choice 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 Choice should focus on enhancing areas of care</p>	<p>Hamaspik Choice continuously downloads quality data from our Uniform Assessment System analyzer tool to identify current quality measure performances against state averages. Based on our rates, we launch campaigns and revise internal workflows to address areas where we may be lower than state averages and track our improvement rates. Additionally, Hamaspik Choice reviews IPRO’s survey outcomes as received and shapes quality improvement initiatives to address and improve the areas in</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Hamaspik Choice's Response	IPRO'S Assessment of Hamaspik Choice's Response
where its rates are below the Medicaid Managed Long-term Care program mean.	which our members are reporting negatively.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Hamaspik Choice should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. Hamaspik Choice should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Hamaspik Choice's compliance department includes staff who conduct internal audits focused on key elements of Medicaid Long-Term Care and Medicaid Advantage Plus compliance. Audits include care management contact frequency and supporting 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, utilization of key services that determine member eligibility, and others.	Addressed.
Network Adequacy		
It is recommended Hamaspik Choice 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.	Hamaspik Choice actively monitors our network for sufficiency per Centers for Medicare & Medicaid Services and the New York State Department of Health guidelines. Hamaspik Choice ensures an adequate network of providers for each specialty in each county of service. Since the 2023 review was complete, we have contracted with new providers in each county and have closed many of the gaps. Remaining gaps are due to insufficient providers in the service area.	Addressed.
Quality-of-Care Survey		
Hamaspik Choice should evaluate member satisfaction and address adverse member	Hamaspik Choice conducts a post-call survey to all members who call into the plan. Callers are	Addressed.

2023 External Quality Review Recommendation	Hamaspik Choice's Response	IPRO'S Assessment of Hamaspik Choice's Response
experience with areas linked to quality, timeliness, and access to care.	asked questions about their care and experience with Hamaspik Choice and its representatives. Hamaspik Choice contacts all members with negative responses to conduct a more thorough investigation to identify the reason(s) for dissatisfaction and then uses this information to improve workflows and Hamaspik Choice's plan processes.	

Performance Improvement Project Summaries and Results

Table 165: Hamaspik Choice's Performance Improvement Project Summary, 2024

Hamaspik Choice's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of the final measurement year, Hamaspik Choice aims to increase the number of members with no depressive feelings for all members by 3.76% from the baseline measurement year. ▪ By the end of the final measurement year, Hamaspik Choice aims to track all members who reported depressive feelings on the Uniform Assessment System Community Health Assessment and also reported depressive feelings on a follow-up depression screening. ▪ By the end of the final measurement year, Hamaspik Choice aims to have a documented intervention within two weeks of a positive depression screening for 85.00% of members. ▪ By the end of the final measurement year, Hamaspik Choice aims to have a follow up within 60 days of positive depression screening for 85.00% of members. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Created an automated report to monitor and track members across all performance indicators. ▪ Encouraged care managers and nurses to have conversations about depression with members in a manner that makes the member feel comfortable and not stigmatized. ▪ Care managers and nurses received clinical training on the signs and symptoms of depression to identify struggling members and intervene and follow up appropriately. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Created member education tools highlighting key benefits of treating depression and resources as to how to do so.

Hamaspik Choice's Performance Improvement Project Summary

- Collaborated with Licensed Home Care Services Agencies and in-network providers to engage with members with positive depression screenings.

Table 166: Hamaspik Choice's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	81.24%	67.48%	85.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	17.13%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	Not Available	74.70%	85.00%
Percentage of positive depression screens with follow-up	Not Available	90.38%	85.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 167: Hamaspik Choice's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	59%	53%	74%	71%
No Severe Daily Pain	99%	99%	99%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	99%	100%	99%
Effectiveness of Care				
Influenza Vaccination	76%	75%	81%	78%
Pneumococcal Vaccination	83%	85%	91%	83%
COVID-19 Vaccination	Not Available	46%	67%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 168: Hamaspik Choice’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Comprehensive	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	C	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	NC	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	C	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	C	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	NC	NC
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	NC	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	NC	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	C	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed	NC	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	C	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	C	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	NC	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	C	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Person Centered Service Plan Focused Survey.

Table 169: Hamaspik Choice’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Comprehensive Survey		
Hamaspik Choice failed to produce evidence of comprehensive vendor oversight for Social Day Care providers to assure compliance with all requirements of 9 New York Code of Rules and Regulations 6654.20.	Managed Long Term Care Contract Article VII C.2	438.206
Thirty-three records submitted for review did not show evidence of a 6 month in-person care management home visit.	Partial Capitation Contract Article V J.6.b	438.100
Ten records submitted for review that indicated the enrollee was receiving consumer directed personal assistance services did not contain complete or updated physicians orders that covered the full review period.	New York Code of Rules and Regulations Title 18	438.208
For ten prior authorization or concurrent reviews following a service request, no evidence was provided that the determination notice was sent within the required timeframe.	Partial Capitation Contract Appendix K	438.210
Hamaspik Choice failed to provide evidence of a current license for a health professional/care manager providing covered services (care management) to a plan enrollee.	Managed Long Term Care Contract Part 98-1.12(k)	438.214
Five records submitted for review contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment, did not contain the projected date of enrollment, and/or was not signed by the enrollee/representative.	Partial Capitation Contract Article V H.5	438.242
For one appeal, no evidence was provided that the determination notice was sent within the required timeframe.	Partial Capitation Contract Appendix K (grievance)	438.228
Person Centered Service Plan Focused Survey		
The majority of Person Centered Service Plans reviewed lacked completed elements, such as Primary Care Provider information, member preferences and strengths, unit and frequency of supplies, residential setting and supports, backup plan, and Person Centered Service Plan process	Partial Capitation Contract Article V J.c.iv-vii Article V J.9.d.viii	438.208

<p>information. In addition, in care management notes and member Person Centered Service Plan forms, notations regarding, member preferences and strengths did not appear to be member-driven, as required.</p>		
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Network Adequacy Results

Table 170: Hamaspik Choice’s Network Gaps, 2024

Hamaspik Choice Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care		3	2	3		3	7	6								
Audiology Services	1		1		2	1	2	1								
Institutional Long Term Care						1	1	4								
Institutional Long Term Care (AIDS Skilled Nursing Facility)			3	3			2	2								
Institutional Long Term Care (Vent Skilled Nursing Facility)			1	1			4	3								
Institutional Short Term Care						1	1									
Optometry	2	2	2	2												
Oral Surgery		1	1	1	2	1	1	1								
Podiatry						1										
Private Duty Nursing							1	1								
Social Day Care								1								
Telehealth	1	1	1	2												
Therapy: Physical	1															
Therapy: Speech and Language	5		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.

Strengths, Opportunities for Improvement, and Recommendations

Table 171: Hamaspik Choice Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Hamaspik Choice’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	One of three performance improvement project indicator rates exceeded Hamaspik Choice’s target rate.	X	X	X
Performance Measures	Six performance measure rates calculated by the Department of Health for Hamaspik Choice for measurement year 2024 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review, Hamaspik Choice was in compliance with seven standards of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	Hamaspik Choice met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One performance improvement project indicator rate reported by Hamaspik Choice demonstrated a decline between measurement years 2023 and 2024. Two of three performance improvement project indicator rates reported by Hamaspik Choice did not reach their target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik Choice for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review activities, Hamaspik Choice was not in compliance with seven standards of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	Hamaspik Choice 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.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Hamaspik Choice 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 Choice 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 Choice 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 Choice 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 Choice 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

HomeFirst

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

In measurement year 2023, HomeFirst operated under the name Elderplan.

Table 172: HomeFirst’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	HomeFirst’s Response	IPRO’S Assessment of Homefirst’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, HomeFirst 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>HomeFirst continued to exceed project goals of social determinant of health completion and care management contact. Care managers completed social determinant of health assessments with every care planning call to identify social barriers and risks as well as implementing appropriate interventions to address them. The social work coordinator ensured that the targeted interventions were continuously developed and follow up was conducted as needed. Ongoing education was provided to all care management staff to ensure member needs were met and outcomes were properly monitored.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>HomeFirst 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, HomeFirst</p>	<p>HomeFirst members are frail with many health issues. HomeFirst continued to focus on preventing worsening shortness of breath through disease management, transitions of care programs, community-based organization partnerships for home visits post-acute episode, certified home health aide referrals, and ongoing member education on disease progression. HomeFirst utilized the plan-do-study-act methodology to determine program effectiveness.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	HomeFirst's Response	IPRO'S Assessment of Homefirst's Response
<p>should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.</p>	<p>HomeFirst data measured over time for the shortness of breath measure revealed successful program outcomes, as the rate was 93%, above the statewide average.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>HomeFirst 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>HomeFirst implemented corrective action plans to address all comprehensive and focused survey findings. Corrective action plans were approved by the New York State Department of Health. Routine monitoring and auditing are conducted to ensure corrective action plans are fully implemented and effective to assess for noncompliance, fraud, waste, and abuse within the following operational areas: risk areas of enrollment, call center, care management, pre and post-service requests, appeals and grievances, pharmacy, quality improvement, network and contracting, marketing, and vendor oversight.</p>	<p>Addressed.</p>
<p>Network Adequacy</p>		
<p>It is recommended HomeFirst 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.</p>	<p>HomeFirst reviews network gaps monthly by conducting analyses of the provider network data system test submissions, network adequacy vendor market data, and provider network terminations. Outreach is conducted to potential providers to commence contract negotiations and ongoing follow up to contract and credential providers. HomeFirst also coordinates recruitment with vendors as needed. This process aids in reducing network gaps identified in the quarterly Statement of Agreement.</p>	<p>Addressed.</p>
<p>Quality-of-Care Survey</p>		

2023 External Quality Review Recommendation	HomeFirst's Response	IPRO'S Assessment of Homefirst's Response
HomeFirst should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	HomeFirst conducts periodic off-season surveys to evaluate member satisfaction with HomeFirst, care managers, regular visiting nurses, and home health aides. HomeFirst also assesses involvement in making decisions and managing illness, as well as whether the member has talked about appointing someone for health decisions. Improved results have been observed.	Addressed.

Performance Improvement Project Summaries and Results

Table 173: HomeFirst's Performance Improvement Project Summary, 2024

HomeFirst's Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
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"> ▪ By the end of the final measurement year, HomeFirst aims to increase the percentage of members reporting no depressive feelings by 7.60% from the baseline measurement year. ▪ By the end of the final measurement year, HomeFirst aims to increase the percentage of members reporting depressive feelings that had a follow-up positive depression screen by 33.00%. ▪ By the end of the final measurement year, HomeFirst aims to increase the percentage of members with a documented intervention within two weeks of a positive depression screening by 33.00% ▪ By the end of the final measurement year, HomeFirst aims to increase the percentage of members with a follow up within 60 days after a positive depression screening by 33.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ HomeFirst implemented a system which alerts care management staff to conduct follow-up screening for members reporting feeling sad, depressed, or hopeless in the last three days. ▪ HomeFirst conducted staff trainings on completion of the Major Depression Inventory Screening Tool. ▪ HomeFirst conducted trainings annually for existing staff and as part of new staff orientation. ▪ HomeFirst updated current workflows to trigger appropriate intervention for members with a Major Depression Inventory Screening Tool score of: 25-29 (moderate depression), and 30+ (severe depression).

Table 174: HomeFirst’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	76.39%	53.02%	84.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	58.10%	33.00% ¹
Percentage of positive depression screens that have a documented intervention	0.00%	79.08%	33.00%
Percentage of positive depression screens with follow-up	0.00%	79.08%	33.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 175: HomeFirst’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	48%	47%	47%	71%
No Severe Daily Pain	100%	99%	99%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	73%	78%	76%	78%
Pneumococcal Vaccination	79%	81%	82%	83%
COVID-19 Vaccination	Not Available	78%	90%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 176: HomeFirst’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Comprehensive	2023 Focused ²	2023 Focused ³	2024 Focused ⁴
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	C	Not Reviewed	NC	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	C	NC	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	NC	Not Reviewed	NC	Not Reviewed
438.214: Provider Selection	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	C	Not Reviewed	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	C	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Social Day Care Reduction Focused Survey.

⁴ Site Evaluation Focused Survey.

Table 177: HomeFirst’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
HomeFirst failed to produce evidence of vendor oversight for Social Day Care providers to assure compliance with 9 New York Code of Rules and Regulations 6654.20.	Partial Capitation Contract Article VII C	438.206

Network Adequacy Results

Table 178: HomeFirst’s Network Gaps, 2024

HomeFirst Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1	2	4	4	3	4	2	2								
Audiology Services	3	4	4	4	1	1	2	1								
Fiscal Intermediary		1														
Institutional Long Term Care							1									
Institutional Long Term Care (AIDS Skilled Nursing Facility)					1	1	1	1								
Optometry		1	1		1			1								
Oral Surgery	1	2	2	2	3	1	2	2								
Social Day Care		1	2	3	3	1	2	1	1					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.

Strengths, Opportunities for Improvement, and Recommendations

Table 179: HomeFirst’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	HomeFirst’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Three of four performance improvement project indicator rates reported by HomeFirst demonstrated improvement between measurement years 2023 and 2024. Three of four performance improvement project indicator rates exceeded HomeFirst’s target rates.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for HomeFirst for measurement year 2024 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	HomeFirst met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by HomeFirst demonstrated a decline between measurement years 2023 and 2024. One of four performance improvement project indicator rates reported by HomeFirst did not reach the target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for HomeFirst for measurement year 2024 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 2024 review, HomeFirst was not in compliance with one standard of 42 Code Federal Regulations Part 438.	X	X	X
Network Adequacy	HomeFirst 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, HomeFirst 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	HomeFirst 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, HomeFirst 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	HomeFirst 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 HomeFirst 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.			

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 180: iCircle’s Response to the 2023 External Quality Review Recommendations

2023 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 continues to monitor the effectiveness of implemented interventions of both current and prior performance improvement projects. Assessment and screening of social determinants of health needs are still completed with applicable interventions initiated. Also, iCircle continues to analyze current project interventions on a quarterly basis. In the event an original intervention is yielding low results, alternative interventions are executed and tracked for barriers, success and risks.</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 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>iCircle continues to target areas of care with low performance measure rates. iCircle’s strategy includes proactively reviewing care needs, targeting health outcome initiatives, monitoring members' unique health needs, and collaboration with community partners to address health disparities. iCircle consistently analyzes alternative approaches to ensure favorable health outcomes.</p>	<p>Partially addressed.</p>

2023 External Quality Review Recommendation	iCircle's Response	IPRO'S Assessment of iCircle's Response
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
<p>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.</p>	<p>iCircle focuses on areas of non-compliance that have been identified by the New York State 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. iCircle's quality and compliance department reviews and monitors the areas of non-compliance and then guides efforts to address performance areas below the Medicaid Managed Long-Term Care program averages.</p>	<p>Partially addressed.</p>
Network Adequacy		
<p>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.</p>	<p>iCircle actively reviews network adequacy in accordance with network submission through the Provider Network Data System. Contracting efforts are continuous, utilizing both available providers via our issued Statement of Agreement, as well as referencing available service types through Quest Analytics. Monitoring and gap analysis is also completed proactively prior to any need for removal of a participating provider, should that be necessary.</p>	<p>Addressed.</p>
Quality-of-Care Survey		
<p>iCircle should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.</p>	<p>iCircle implemented a bi-annual member satisfaction survey through care management, with monthly call outreach to assess member experience and satisfaction. The results of these outreaches are reviewed. Adverse member experiences are analyzed and are addressed</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	iCircle's Response	IPRO'S Assessment of iCircle's Response
	either on an individual level, or at the iCircle plan level as applicable. Additionally, iCircle uses a variety of data sources to track and monitor member experience and conducts follow-ups as needed to continue to improve the member experience.	

Performance Improvement Project Summaries and Results

Table 181: iCircle's Performance Improvement Project Summary, 2024

iCircle's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of 2025, iCircle aims to achieve a two percentage point increase in continuously enrolled members that report no depressive feelings. ▪ By the end of 2025, iCircle aims to achieve a 25.00% decrease in continuously enrolled members reporting depressive feelings and whose follow-up depression screen was positive. ▪ By the end of 2025, iCircle aims to achieve an 80.00% rate of continuously enrolled members who have a documented intervention within 2 weeks of a positive depression screening. ▪ By the end of 2025, iCircle aims to achieve a 70.00% rate of continuously enrolled members that receive follow up within 60 days of a positive depression screening. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Developed and integrated a depression screening tool and corresponding workflows into iCircle's clinical platform. ▪ Educated staff on depression disorders, how to complete a depression screening, and compassion-focused interventions (cultural competency, combating mental health stigma).

Table 182: iCircle’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	58.74%	58.28%	60.74%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	30.67%	25.00% ¹
Percentage of positive depression screens that have a documented intervention	Not Available	72.60%	80.00%
Percentage of positive depression screens with follow-up	Not Available	56.14%	70.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 183: iCircle’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	45%	43%	44%	71%
No Severe Daily Pain	76%	78%	78%	96%
Pain Controlled	80%	82%	82%	98%
Not Lonely and Distressed	84%	86%	87%	99%
Effectiveness of Care				
Influenza Vaccination	70%	69%	67%	78%
Pneumococcal Vaccination	77%	76%	73%	83%
COVID-19 Vaccination	Not Available	65%	50%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 184: iCircle’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 185: iCircle’s Network Gaps, 2024

iCircle Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care		1				1	1	2								
Audiology Services		6	10	14		3	2									
Certified Home Health				1	1	3	6	7								
Certified Home Health: Home Based Medical Social Services				1	1	3	6	7								
Certified Home Health: Home Based Occupational Therapy				1	1	3	6	7								
Certified Home Health: Home Based Physical Therapy				1	1	3	5	6								
Certified Home Health: Home Based Speech Therapy				1	1	3	6	7								
General Dentistry			2	1			1	2								
Institutional Long Term Care						1	1	1								
Institutional Long Term Care (Vent Skilled Nursing Facility)				1	1	1	2	1								
Institutional Short Term Care						1	1	1								
Licensed Home Health Care: Home Based Medical Social Services	2	1	1	6	4	8	10	9								
Licensed Home Health Care: Home Based Occupational Therapy	2	2	3	10	4	9	8	5								
Licensed Home Health Care: Home Based Physical Therapy	2	1	1	6	2	10	9	9								
Licensed Home Health Care: Home Based Speech Therapy	2	1	4	10	5	10	6	6								
Optometry		1		1		1	2	1								
Oral Surgery		2	12	15		3	2	1		1	1			2	1	

iCircle Network Gaps, 2024

Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Podiatry			1	4			2	3								
Social Day Care		1		2		2	5	5							1	
Telehealth				1			2	3								
Therapy: Occupational			1		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.

Strengths, Opportunities for Improvement, and Recommendations

Table 186: 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 2024.			
	One performance improvement project indicator rate reported by iCircle was maintained between measurement years 2023 and 2024. One of four performance improvement project indicator rates exceeded iCircle’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	iCircle met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Three of four performance improvement project indicator rates reported by iCircle did not reach the target rate.	X	X	X
Performance Measures	All seven performance measure rates calculated by the Department of Health for iCircle for measurement year 2024 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	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
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project, Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy	iCircle’s membership was acquired by VNS Health Choice on 04/01/2026. At the time of this report’s publishing, iCircle is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendations were made.			

Kalos Health Inc.

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Kalos Health Inc. was acquired by VNS Health Choice effective 12/01/2024.

Performance Improvement Project Summaries and Results

Kalos Health Inc. was acquired by VNS Health Choice effective 12/01/ 2024.

Performance Measure Results

Table 187: Kalos Health Inc.'s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	54%	58%	59%	71%
No Severe Daily Pain	97%	100%	100%	96%
Pain Controlled	93%	98%	100%	98%
Not Lonely and Distressed	90%	96%	99%	99%
Effectiveness of Care				
Influenza Vaccination	71%	72%	70%	78%
Pneumococcal Vaccination	84%	83%	77%	83%
COVID-19 Vaccination	Not Available	78%	72%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 188: Kalos Health Inc.’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Comprehensive	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	C	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	C	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	C	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	NC	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	C	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	C	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	C	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	C	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	NC	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	C	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 189: Kalos Health Inc.'s Network Gaps, 2024

Kalos Health Inc. Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care					2	3	2									
Audiology Services			1													
Certified Home Health					1	1	1									
Certified Home Health: Home Based Medical Social Services					1	1	1									
Certified Home Health: Home Based Occupational Therapy					1	1	1									
Certified Home Health: Home Based Physical Therapy						1	1									
Certified Home Health: Home Based Speech Therapy						1	1									
Fiscal Intermediary						1										
Institutional Long Term Care (Vent Skilled Nursing Facility)													2			
Licensed Home Health Care: Home Based Physical Therapy					1											
Licensed Home Health Care: Home Based Speech Therapy					1											
Oral Surgery							1									
Social Day Care		1			2	2	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 190: Kalos Health Inc.’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	None.			
	None.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Kalos Health Inc. for measurement year 2024 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 Inc. met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Kalos Health Inc. for measurement year 2024 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	Kalos Health Inc. 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
Recommendations				
Performance Improvement Project,	Kalos Health Inc.’s membership was acquired by VNS Health Choice effective 12/01/2024; Kalos Health Inc. is no longer participating in the New			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures, Compliance with Federal Managed Care Standards, Network Adequacy	York State Medicaid Managed Care Program and therefore no recommendations were made.			

MetroPlus Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 191: MetroPlus Health’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	MetroPlus Health’s Response	IPRO’S Assessment of MetroPlus Health’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, MetroPlus 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>MetroPlus Health continuously monitors and reviews social determinants of health at the time of routine Uniform Assessment System assessments. Care managers address social determinants of health needs during monthly member calls and provide interventions and available resources at that time. Continuation of this project enables ongoing quality improvement in social determinants of health screening and follow-up. Monthly reports are run to track data and are also shared with staff. MetroPlus Health conducts refresher trainings as needed and based on any trends that are identified.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>MetroPlus 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, MetroPlus Health should focus</p>	<p>MetroPlus Health utilizes an assessment analysis platform to continuously monitor and track care gaps noted on the Uniform Assessment System assessment. After the assessor and quality teams identify care gaps, the care management team develops an individualized plan of care with the member, establishing achievable goals and interventions to improve health outcomes. Interventions are examined during routine contacts with members. Refresher trainings</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	MetroPlus Health's Response	IPRO'S Assessment of MetroPlus Health's Response
on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	are provided to staff on addressing and closing of care gaps.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
MetroPlus Health 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.	MetroPlus Health continues to maintain a compliance program with an assigned compliance specialist to ensure adherence to all applicable requirements. Through a risk assessment, MetroPlus Health's 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.
Network Adequacy		
It is recommended MetroPlus 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.	The MetroPlus Health contracting team partners with the provider network operations team to identify network gaps as reported through the quarterly Provider Network Data System submissions. If gaps are identified, the contracting team identifies providers who may fill the gaps and reaches out to those providers in an effort to establish a contractual relationship. This process is repeated each calendar quarter. Additionally, MetroPlus Health routinely monitors market data and other provider directories for contracting opportunities.	Addressed.
Quality-of-Care Survey		
MetroPlus Health should evaluate member satisfaction and address adverse member experience with areas linked to	MetroPlus Health increased its monitoring of member satisfaction by creating an ad-hoc satisfaction survey using a performance	Addressed.

2023 External Quality Review Recommendation	MetroPlus Health's Response	IPRO'S Assessment of MetroPlus Health's Response
quality, timeliness, and access to care.	feedback platform. Survey results are monitored regularly to identify dissatisfaction and guide improvement strategies by the Managed Long-Term Care quality team, which are then shared with the care manager. During monthly calls, member concerns are addressed to improve quality, timeliness, and access to care.	

Performance Improvement Project Summaries and Results

Table 192: MetroPlus Health's Performance Improvement Project Summary, 2024

MetroPlus Health's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of 2025, MetroPlus Health aims to increase the percentage of members reporting no depressive feelings to 95.00%. ▪ By the end of 2025, MetroPlus Health aims to complete a Patient Health Questionnaire-9 for all members with a positive depression screening from the Uniform Assessment System Community Health Assessment. ▪ By the end of 2025, MetroPlus Health aims to increase the percentage of documented interventions for members within two weeks of a positive depression screening to 85.00% ▪ By the end of 2025, MetroPlus Health aims to increase the percentage of follow ups within 60 days with members who had a positive depression screening to 97.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Provided training presentations and online courses (via Lenavi software) to plan staff on the impact of depression on members' health, social, and functional status. ▪ Introduced and trained staff on the Patient Health Questionnaire-9 screening tool. ▪ Implemented a standardized process for administering the Patient Health Questionnaire-9 Screening Tool to members that had a positive depression screening during the Uniform Assessment System Community Health Assessment. ▪ Established a consistent protocol for timely referral of members with positive Patient Health Questionnaire-9 Screening Tool results to appropriate services and supports. ▪ Developed reports tracking Patient Health Questionnaire-9 Screening Tool completion by business line, including member scores and responses.

Table 193: MetroPlus Health’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	90.73%	91.55%	95.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	85.21%	97.68%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	80.99%	100.00%	85.00%
Percentage of positive depression screens with follow-up	62.81%	98.81%	97.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 194: MetroPlus Health’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	90%	92%	91%	71%
No Severe Daily Pain	100%	98%	97%	96%
Pain Controlled	98%	96%	94%	98%
Not Lonely and Distressed	99%	99%	97%	99%
Effectiveness of Care				
Influenza Vaccination	83%	78%	76%	78%
Pneumococcal Vaccination	81%	77%	78%	83%
COVID-19 Vaccination	Not Available	84%	86%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 195: MetroPlus Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Comprehensive	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	NC	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	C	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	C	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	C	C	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	NC	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	C	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	C	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	C	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	C	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	C	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	NC	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	C	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 196: MetroPlus Health’s Network Gaps, 2024

MetroPlus Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Medical Social Services					4											
Licensed Home Health Care: Home Based Speech Therapy					4											
Private Duty Nursing	1	1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 197: MetroPlus Health’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus Health’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Three of four performance improvement project indicator rates reported by MetroPlus Health demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of three performance improvement project indicator rates exceeded MetroPlus Health’s target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for MetroPlus Health for measurement year 2024 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 Health met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of three performance improvement project indicator rates reported by MetroPlus Health did not meet MetroPlus Health’s target rate.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for MetroPlus Health for measurement year 2024 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	MetroPlus 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MetroPlus 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	MetroPlus 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, MetroPlus 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	MetroPlus 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 MetroPlus 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

Montefiore

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Montefiore ceased operations within measurement year 2023. Montefiore was acquired by RiverSpring At Home on 01/01/2024.

Performance Improvement Project Summaries and Results

Montefiore ceased operations within measurement year 2023. Montefiore was acquired by RiverSpring At Home on 01/01/2024.

Performance Measure Results

Montefiore ceased operations within measurement year 2023. Montefiore was acquired by RiverSpring At Home on 01/01/2024.

Compliance with Medicaid and Children's Health Insurance Program

Standards Results

Table 198: Montefiore's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Comprehensive	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	C	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	C	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	C	Not Reviewed
438.206: Availability of Services	Not Reviewed	C	C
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	NC	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	C	Not Reviewed
438.214: Provider Selection	Not Reviewed	NC	Not Reviewed
438.224: Confidentiality	Not Reviewed	C	Not Reviewed
438.228: Grievance and Appeal System	C	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	NC	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	C	Not Reviewed
438.242: Health Information Systems	Not Reviewed	NC	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	C	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Montefiore ceased operations within measurement year 2023. Montefiore was acquired by RiverSpring At Home on 01/01/2024.

Strengths, Opportunities for Improvement, and Recommendations

Montefiore ceased operations within measurement year 2023. Montefiore was acquired by RiverSpring At Home on 01/01/2024.

Nascentia Health Options

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 199: Nascentia Health Options’ Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Nascentia Health Option’s Response	IPRO’S Assessment of Nascentia Health Option’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Nascentia Health Options 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 Health Options has created a daily operational report that includes the goals of our performance improvement project and serves as a daily assessment of our progress. The operational report is reviewed daily by supervisors in a huddle and any gaps are documented and brought forward for follow up in real time. The regional program directors ensure all follow up is completed and to those involved if needed. Interventions are also reviewed for effectiveness and adjusted as needed.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Nascentia Health Options 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 Health Options should focus on enhancing areas of care where its rates are below the</p>	<p>Nascentia Health Options has developed a member assessment process to improve preventative care and effectiveness of care measures. Nascentia Health Options members are identified who exhibit a decline or need for preventative services based on the Uniform Assessment System. This assessment process is completed prior to their next Uniform Assessment System assessment. Nascentia Health Options teams meet monthly to address and discuss interventions and any connection to services. Information that is relevant is</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Nascentia Health Option's Response	IPRO'S Assessment of Nascentia Health Option's Response
<p>Medicaid Managed Long-term Care program mean.</p>	<p>forwarded to the Nurse assessor for the next Uniform Assessment System to address. Supervisors in turn ensure interventions and any follow up are completed.</p>	
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<p>Nascentia Health Options should ensure its compliance with federal and state Medicaid standards by continuing its initiatives in place to address the 2023 compliance findings. Nascentia Health Options should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>Nascentia Health Options conducts routine audits to assess adherence to program standards. Results are shared monthly with the focus being on improvement. Nascentia Health Options has also instituted round-table discussions that include care managers and leaders to identify potential barriers to compliance and institute process changes to simplify steps and improve compliance. This approach has been implemented for member care plans, coverage and service authorizations and has resulted in improved compliance.</p>	<p>Addressed.</p>
<p>Network Adequacy</p>		
<p>It is recommended Nascentia Health Options 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.</p>	<p>Nascentia Health Options Provider Relations reviews the quarterly deficiency report, cross references it with the provider network report and Provider Network Data System submission, and then identifies noncontracted providers in counties where the provider type is available. Nascentia Health Options also utilizes Quest in the Provider Network Data System submission, the Medicaid Management Information System lookup tool, and the Health Facilities Information System. Monthly outreach is conducted and tracked in a centralized log and re-engagement occurs with providers who previously declined. Nascentia Health Options also authorize non-contracted</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Nascentia Health Option's Response	IPRO'S Assessment of Nascentia Health Option's Response
	providers to ensure members receive timely care.	
Quality-of-Care Survey		
Nascentia Health Options should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Members are educated on routine dental exams to avoid emergency situations. Assistance is provided with scheduling appointments and Teledental Services are encouraged for emergent same day needs. Any complaints are escalated to our provider relations team and dental network for investigation and resolution. If an in-network provider cannot be found, out of network will be considered. Quality is monitored through complaint trending, access tracking and member satisfaction.	Addressed.

Performance Improvement Project Summaries and Results

Table 200: Nascentia Health Options' Performance Improvement Project Summary, 2024

Nascentia Health Option's Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
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"> ▪ By the end of the final measurement year, Nascentia Health Options aims to increase the number of continuously enrolled members reporting no symptoms or feelings of depression by fifteen percentage points from the baseline measurement year. ▪ By the end of the final measurement year, Nascentia Health Options aims to increase the number of follow up depression screenings for members reporting symptoms or feelings of depression by 50.00%. ▪ By the end of the final measurement year, Nascentia Health Options aims to increase documented interventions within two weeks following a positive depression screening by 60.00%. ▪ By the end of the final measurement year, Nascentia Health Options aims to increase follow up within 60 days for members with positive depression screening by 25.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Conducted staff training sessions (for current and onboarding staff members) on depression and the administration of the Patient Health Questionnaire-9 Screening Tool, scoring, stratification, and potential interventions.

Nascentia Health Option's Performance Improvement Project Summary

- Developed a system for ongoing tracking of positive depression screening results.

Member-Focused 2024 Interventions

- Provided members with educational material on depression including the potential impact on overall health, and the importance of accurate screening to help identify needs. Nascentia Health Options provided educational materials at the time of initial assessment and via a quarterly Member Newsletter.
- Care Managers referred members to their primary care providers for expedited linkage referrals to mental health services and/or referral to a Virtual Senior Center.

Table 201: Nascentia Health Options' Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	69.85%	82.71%	85.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	14.59%	50.00% ¹
Percentage of positive depression screens that have a documented intervention	0.00%	54.22%	60.00%
Percentage of positive depression screens with follow-up	0.00%	7.23%	25.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 202: Nascentia Health Options' Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	54%	50%	55%	71%
No Severe Daily Pain	94%	95%	98%	96%
Pain Controlled	93%	93%	97%	98%
Not Lonely and Distressed	97%	97%	98%	99%
Effectiveness of Care				
Influenza Vaccination	70%	71%	71%	78%
Pneumococcal Vaccination	75%	76%	79%	83%
COVID-19 Vaccination	Not Available	76%	79%	80%

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
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¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 203: Nascentia Health Options’ Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 204: Nascentia Health Options' Network Gaps, 2024

Nascentia Health Options Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	9	10	8	7	5	5	11	7		1			1	1	1	
Audiology Services	11	9	13	11	2	1										
Certified Home Health			1		4	9	6	7								
Certified Home Health: Home Based Medical Social Services			1	3	7	9	7	8								
Certified Home Health: Home Based Occupational Therapy		1	1	2	5	7	6	8								
Certified Home Health: Home Based Physical Therapy		1	1	2	5	7	6	8								
Certified Home Health: Home Based Speech Therapy		1	1	3	5	8	6	7								
Fiscal Intermediary	11	1	3	24	3	1	4	8	2				2	1		
General Dentistry		34	2	2	1		1	1		2						
Institutional Long Term Care	1	1	1	1	4	2	4	2								
Institutional Long Term Care (AIDS Skilled Nursing Facility)	14								20				1			
Institutional Long Term Care (Vent Skilled Nursing Facility)	11	3	3	3	3	2	1	2	10				6			
Institutional Short Term Care	1	1	1	1	3	4	3	3								
Licensed Home Health Care: Home Based Physical Therapy	7	14	9	12	14	9	9	9								
Licensed Home Health Care: Home Based Medical Social Services	11	11	10	13	14	10	10	12								
Licensed Home Health Care: Home Based Occupational Therapy	10	14	8	12	14	12	10	13								

Nascentia Health Options Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Speech Therapy	13	18	12	16	23	16	16	18								
Moving Assistance										1						
Optometry	3	3	2	3	4	2	1									
Oral Surgery	11	17	13	18	3		6	2	3	19			1		2	
Podiatry	5	6	6	6	9	8	9	7					1	1		
Social Day Care	4	3		7	8	8	6	4					1	1	1	
Telehealth	11	9	9	10	5	4	9	7	3	4			6	1	1	
Therapy: Occupational	7	7	3	8	2	1	1	1								
Therapy: Physical	3	4		3	1		1	1								
Therapy: Speech and Language	10	9	5	9	2	1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 205: Nascentia Health Options’ Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Nascentia Health Options performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Four of four performance improvement project indicator rates reported by Nascentia Health Options demonstrated improvement between measurement years 2023 and 2024.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Nascentia Health Options for measurement year 2024 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	Nascentia Health Options met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	None of the performance improvement indicator rates reported by Nascentia Health Options met the target rates.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Nascentia Health Options for measurement year 2024 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	None.			
Network Adequacy	Nascentia Health Options 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Nascentia Health Options 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 Health Options 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 Health Options 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 Nascentia Health Options 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

Prime Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Prime Health was acquired by VNS Health Choice effective 05/01/2024.

Performance Improvement Project Summaries and Results

Prime Health was acquired by VNS Health Choice effective 05/01/ 2024.

Performance Measure Results

Prime Health was acquired by VNS Health Choice effective 05/01/ 2024.

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

Table 206: Prime Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Comprehensive	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	C	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	C	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	C	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	NC	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	NC	Not Reviewed
438.214: Provider Selection	Not Reviewed	NC	Not Reviewed
438.224: Confidentiality	Not Reviewed	C	Not Reviewed
438.228: Grievance and Appeal System	C	NC	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	NC	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	C	Not Reviewed
438.242: Health Information Systems	Not Reviewed	C	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	C	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 207: Prime Health’s Network Gaps, 2024

Prime Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care					3											
Audiology Services	3	2				1			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											
Institutional Long Term Care					2	3										
Institutional Long Term Care (Vent Skilled Nursing Facility)	2	2							3							
Institutional Short Term Care	3	1														
Licensed Home Health Care: Home Based Medical Social Services					1											
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	3				2											
Nutrition	2	1														
Optometry	1															
Oral Surgery	1															

Prime Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Podiatry	2				3	1										
Social Day Care		1			1	2										
Social and Environmental Support		1														
Telehealth	3				2	2			1							
Therapy: Occupational		1			1											
Therapy: Respiratory	5	1														
Therapy: Speech and Language		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.

Strengths, Opportunities for Improvement, and Recommendations

Prime Health was acquired by VNS Health Choice effective 05/01/2024.

RiverSpring at Home

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 208: RiverSpring at Home’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	RiverSpring at Home’s Response	IPRO’S Assessment of RiverSpring at Home’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, RiverSpring at Home 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>RiverSpring at Home monitors improvement plans continuously throughout the project through case reviews, auditing, and report generating. When interventions are confirmed as evidenced by progress towards meeting goals, those interventions continue. Also, any negative outcomes are reviewed to determine why the intervention(s) is not effective and to identify new interventions that may better serve the goals set to improve the members outcomes. This process is an ongoing component of quality assurance.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>RiverSpring at Home 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 at Home should focus on enhancing areas of</p>	<p>RiverSpring at Home conducts and reviews community health assessment data and member satisfaction for areas of opportunity to improve member outcomes. For example, RiverSpring at Home members are below statewide average in receiving vaccines and pain control. In response, a pain assessment was added to the care manager assessment so that any member’s pain is addressed with interventions with the goal being to reduce or even alleviate the member’s pain. Additionally, RiverSpring at Home has partnered</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	RiverSpring at Home's Response	IPRO'S Assessment of RiverSpring at Home's Response
care where its rates are below the Medicaid Managed Long-term Care program mean.	with community providers to provide immunizations to members in their home.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
RiverSpring at Home should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings. RiverSpring at Home should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	RiverSpring at Home conducts monthly auditing and monitoring of operations as part of its quality and compliance program. Results are reported to stakeholders at minimum quarterly with significant deviations reported to stakeholders immediately so that corrective actions may be initiated. Auditing focuses on regulatory compliance and quality of care delivery to RiverSpring at Home's membership with a goal of providing optimal support and services to improve member health and overall well-being.	Addressed.
Network Adequacy		
It is recommended RiverSpring at Home 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.	RiverSpring at Home pursues contracts with providers in the specified counties to fill any identified gaps in our network. This process involves identifying available providers, negotiating contracts, and ensuring these contracts meet the needs outlined in our Statement of Agreement. By doing so, RiverSpring at Home aims to enhance our network and better serve our members.	Addressed.
Quality-of-Care Survey		
RiverSpring at Home should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Member satisfaction is monitored by direct member feedback, Member Advisory Committees, meetings with the care manager and through tracking member complaints with a response provided to the member. Providers with multiple complaints are removed from the network. RiverSpring at Home staff are	Addressed.

2023 External Quality Review Recommendation	RiverSpring at Home's Response	IPRO'S Assessment of RiverSpring at Home's Response
	educated on topics such as advance directives in order to support the members in making health care and advocacy decisions. As a result, our members continue to rate us above statewide average in member experience.	

Performance Improvement Project Summaries and Results

Table 209: RiverSpring at Home's Performance Improvement Project Summary, 2024

RiverSpring at Home's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> ▪ By the end of 2025, RiverSpring at Home aims to increase the percentage of continuously enrolled members reporting no depressive feelings to 65.00%. ▪ By the end of 2025, RiverSpring at Home aims to increase the percentage of members that had a follow up depression screening within two weeks of a positive depression screening to 15.00%. ▪ By the end of 2025, RiverSpring at Home aims to increase the percentage of documented interventions for members with a positive depression screening to 60.00%. ▪ By the end of 2025, RiverSpring at Home aims to increase the percentage of members with a follow up within 60 days of a positive depression screening to 50.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Developed an alert system to notify the interdisciplinary team when a member should complete a follow-up depression screening. ▪ Added intervention fields and dropdown options within the electronic medical record to document and report member-specific depression interventions, with audit processes to validate data accuracy. ▪ Provided annual refresher training to nurse care managers and managed long-term care staff on depression, evidence-based practices, and community resources. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Educated members with positive depression screenings on the impact of depression, available benefits, and community resources, incorporating member feedback to improve outreach.

Table 210: RiverSpring at Home’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	60.34%	61.54%	65.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	19.12%	15.00% ¹
Percentage of positive depression screens that have a documented intervention	Not Available	68.24%	60.00%
Percentage of positive depression screens with follow-up	Not Available	67.59%	50.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 211: RiverSpring at Home’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	41%	43%	46%	71%
No Severe Daily Pain	100%	99%	99%	96%
Pain Controlled	91%	90%	90%	98%
Not Lonely and Distressed	98%	98%	98%	99%
Effectiveness of Care				
Influenza Vaccination	64%	65%	65%	78%
Pneumococcal Vaccination	59%	60%	61%	83%
COVID-19 Vaccination	Not Available	70%	68%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 212: RiverSpring at Home’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 213: RiverSpring at Home’s Network Gaps, 2024

RiverSpring at Home Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1			1	1	1	1	1								
Audiology Services					1	1	1	1								
Certified Home Health: Home Based Medical Social Services					1	1	1	1								
Fiscal Intermediary	2															
Home Delivered and Congregate Meals					2											
Institutional Short Term Care					1											
Optometry							1	1								
Telehealth	6	1	1	1			1	2								
Therapy: Speech and Language			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.

Strengths, Opportunities for Improvement, and Recommendations

Table 214: RiverSpring at Home’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	RiverSpring at Home’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	One performance improvement project indicator rate reported by RiverSpring at Home demonstrated improvement between measurement years 2023 and 2024. Three of four performance improvement project rates exceeded RiverSpring at Home’s target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for RiverSpring at Home for measurement year 2024 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 at Home met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by RiverSpring at Home did not meet the target rate.	X	X	X
Performance Measures	Six performance measure rates calculated by the Department of Health for RiverSpring at Home for measurement year 2024 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 at Home 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.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, RiverSpring at Home 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 at Home 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 at Home 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 at Home 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 at Home 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

Senior Health Partners

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 215: Senior Health Partners’ Response to the 2023 External Quality Review Recommendations

2023 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 leverage an automated report to flag members due for a social determinants of health assessment and/or missing an intervention. They use an enhanced seven-domain assessment and care plan builder in our electronic health record system, TruCare. Through clinical coaching, system training, and Power Business Intelligence reporting, Care Managers have improved the timeliness of conducting assessments, implementing appropriate interventions, and completing follow-up care.</p>	<p>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 focus on enhancing areas of care where their rates are below the</p>	<p>Senior Health Partners remains focused on integrating performance measures into everyday care processes. Care Managers leverage clinical and social determinants data to conduct targeted outreach and close care gaps. Regular audits of health assessment data drive refinements in care strategies. Our clinical teams routinely review measure and member-level results, adjust approaches, and are recognized for strong performance. Ongoing training is provided to support continuous improvements.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Senior Health Partners' Response	IPRO'S Assessment of Senior Health Partners' Response
Medicaid Managed Long-term Care program mean.		
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 reviewed prior results to confirm compliance with federal and state Medicaid standards. In addition, the Compliance and Regulatory teams worked collaboratively to monitor and review continuing compliance.	Addressed.
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.	To address identified gaps, Senior Health Partners will continue to actively pursue and engage all available qualified Senior Health Partners' providers for contracting providers, with the goal of ensuring comprehensive network coverage across all affected counties.	Addressed.
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.	In response to the 2023 survey results, Senior Health Partners did some surveying to gather feedback. Insights were shared with care managers to help tailor member interactions and home health agencies to address service issues such as consistency of care and punctuality. We remained committed to assessing these areas to identify opportunities for improvement in member satisfaction.	Addressed.

Performance Improvement Project Summaries and Results

Table 216: Senior Health Partners' Performance Improvement Project Summary, 2024

Senior Health Partners' Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By the end of 2025, Senior Health Partners aims to increase depression screening rates for members by 4.09 percentage points, reaching the New York State 2023 90th percentile benchmark of 17% for the HEDIS electronic clinical data systems measure.▪ By the end of 2025, Senior Health Partners aims to improve the rate of members with depression who receive treatment by at least 0.55 percentage points meeting their internal goal of 92.00% and surpassing the Healthy People 2030 target of 69.50%.▪ By the end of 2025, Senior Health Partners aims to increase follow-up rates after positive depression screenings for members by 4.81 percentage points, exceeding the New York State 2023 90th percentile benchmark of 84.00% for the HEDIS electronic clinical data systems measure.
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Developed internal processes and workflows that identify and track a member's depression screening results, as well as the care management follow-up activities.▪ Enhanced the functionality in TruCare by centralizing the Patient Health Questionnaire Screening Tool (previously imbedded in different care management assessments) into a single screening tool.▪ Constructed a job aid and facilitated staff trainings on the new workflow which instruct staff on when/how to intervene after a member has a specific score on the Patient Health Questionnaire-9 Screening Tool.
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Members received an intervention(s) relevant to their Patient Health Questionnaire-9 Screening Tool score, as well as education on depression and behavioral health resources by care management staff during telephonic outreach.

Table 217: Senior Health Partners’ Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	81.73%	83.57%	85.82%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	12.80%	12.85%	17.00% ¹
Percentage of positive depression screens that have a documented intervention	91.45%	93.30%	92.00%
Percentage of positive depression screens with follow-up	93.19%	99.83%	98.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 218: Senior Health Partners’ Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	88%	86%	87%	71%
No Severe Daily Pain	99%	98%	99%	96%
Pain Controlled	97%	98%	98%	98%
Not Lonely and Distressed	97%	98%	99%	99%
Effectiveness of Care				
Influenza Vaccination	70%	71%	71%	78%
Pneumococcal Vaccination	66%	68%	72%	83%
COVID-19 Vaccination	Not Available	73%	82%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 219: Senior Health Partners’ Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 220: Senior Health Partners' Network Gaps, 2024

Senior Health Partners Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	2	1	2	2		1										
Fiscal Intermediary		1														
Institutional Long Term Care (AIDS Skilled Nursing Facility)				1												
Institutional Long Term Care (Vent Skilled Nursing Facility)								1								
Podiatry								1								
Private Duty Nursing						1	1									
Telehealth		1		1		1										
Therapy: Speech and Language	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 221: 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 2024.			
	Three of four performance improvement project indicator rates reported by Senior Health Partners demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of four performance improvement project indicator rates exceeded Senior Health Partners’ target rates.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Senior Health Partners for measurement year 2024 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
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates reported by Senior Health Partners did not meet their target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Senior Health Partners for measurement year 2024 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	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
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 its 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 prepares for the compliance review conducted by the Department of Health.	X	X	X
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

Senior Network Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Senior Network Health was acquired by VNS Health Choice effective 06/01/2024.

Performance Improvement Project Summaries and Results

Senior Network Health was acquired by VNS Health Choice effective 06/01/2024.

Performance Measure Results

Senior Network Health was acquired by VNS Health Choice effective 06/01/2024.

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

Table 222: Senior Network Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 223: Senior Network Health’s Network Gaps, 2024

Senior Network Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Audiology Services	1															
Institutional Long Term Care (Vent Skilled Nursing Facility)										1						
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														
Oral Surgery	1															
Telehealth		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.

Strengths, Opportunities for Improvement, and Recommendations

Senior Network Health was acquired by VNS Health Choice effective 06/01/2024.

Senior Whole Health

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 224: Senior Whole Health’s Response to the 2023 External Quality Review Recommendations

2023 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 regularly analyzes health assessment data to enhance quality assurance and success in performance improvement plans. Senior Whole Health identifies gaps in care for social determinants of health, increasing the volume of assessments for new enrollees, and implementing appropriate social determinants of health interventions. Senior Whole Health continues to provide those services for members within their own zip codes through an online platform. Senior Whole Health believes our approach has identified needs, improved rates, and optimized member outcomes with optimal impact.</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</p>	<p>Senior Whole Health will continue to analyze health assessment data to enhance quality assurance. Senior Whole Health has identified trends, quality care gaps, and strengthened interventions with those members determined to be at-risk, in order to utilize best practices which ensure maintenance of high-performance rates.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Senior Whole Health's Response	IPRO'S Assessment of Senior Whole Health's Response
focus on enhancing 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		
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.	Senior Whole Health maintains a proactive and structured approach to compliance through ongoing monitoring, regular training, and risk-based auditing. Guided by continuous risk assessments, the compliance program ensures accountability, drives corrective actions, and fosters a culture of compliance organization-wide.	Addressed.
Network Adequacy		
It is recommended Senior Whole Health continue to pursue provider contracts to expand their provider network.	Senior Whole Health's network adequacy department continues to monitor and ensure no new network adequacy gaps arise.	Addressed.
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.	Senior Whole Health has identified member satisfaction as a concern. Senior Whole Health has analyzed the root causes and reviewed member experiences, focusing on appointing someone for health decisions, requests to see medications, member ratings of Senior Whole Health, and timeliness of care. When members had negative experiences, Senior Whole Health gathered feedback from the quality questionnaire and provided care management interventions that support and strengthen the member's relationship with their care manager.	Addressed.

Performance Improvement Project Summaries and Results

Table 225: Senior Whole Health's Performance Improvement Project Summary, 2024

Senior Whole Health's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By the end of 2025, Senior Whole Health aims to increase the percentage of continuously enrolled members reporting no depressive feelings by 5.00% from the baseline measurement year.▪ By the end of 2025, Senior Whole Health aims to implement the Patient Health Questionnaire-9 screening tool to monitor and trend the percentage of members reporting depressive feelings and had a follow-up positive depression screen.▪ By the end of 2025, Senior Whole Health aims to increase documented interventions for members within two weeks of a positive depression screening by 5.00%.▪ By the end of 2025, Senior Whole Health aims to increase the percentage of follow ups within 60 days of a member's positive depression screening by 5.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Implemented a standardized depression screening tool (Patient Health Questionnaire-9).▪ Developed and implemented an "At-Risk for Depression" alert within the Quality Questionnaire to notify the care management team when the member should complete a depression screening.▪ Trained care management and quality staff on the current end-to-end depression workflow. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Sent educational fliers and conducted telephonic care management follow-up to confirm member's understanding of depression.

Table 226: Senior Whole Health's Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	76.02%	75.25%	79.80%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	5.49%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	0.00%	40.31%	42.30%
Percentage of positive depression screens with follow-up	0.00%	18.13%	19.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 227: Senior Whole Health's Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	86%	76%	85%	71%
No Severe Daily Pain	100%	99%	99%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	99%	100%	99%
Effectiveness of Care				
Influenza Vaccination	84%	83%	84%	78%
Pneumococcal Vaccination	85%	87%	88%	83%
COVID-19 Vaccination	Not Available	89%	89%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 228: Senior Whole Health’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 229: Senior Whole Health’s Network Gaps, 2024

Senior Whole Health Network Gaps, 2024																
Provider Type With A Gap	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Institutional Long Term Care (AIDS Skilled Nursing Facility)			1				1									
Institutional Long Term Care (Vent Skilled Nursing Facility)							1									
Optometry				3				2								
Telehealth			6	7		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.

Strengths, Opportunities for Improvement, and Recommendations

Table 230: 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 2024.			
	Three of four performance improvement project indicator rates reported by Senior Whole Health demonstrated improvement and one was maintained between measurement years 2023 and 2024.	X	X	X
Performance Measures	All seven performance measure rates calculated by the Department of Health for Senior Whole Health for measurement year 2024 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 Whole Health met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	All three performance improvement project indicator rates did not meet Senior Whole Health’s target rates.	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
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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 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.	X	X	X
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 2019-2020 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 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

VillageCareMAX

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 231: VillageCareMAX’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	VillageCareMAX’s Response	IPRO’S Assessment of VillageCareMAX’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, VillageCareMAX 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>VillageCareMAX continued to monitor the Social Determinants of Health Performance Improvement Project. VillageCareMAX held health equity subcommittee meetings throughout the year. The subcommittee used data from social determinants of health assessments, as well as other sources of data to identify health disparities. The subcommittee developed and implemented interventions for the health disparities identified during subcommittee meetings.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>VillageCareMAX 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, VillageCareMAX should focus on enhancing areas of care where its rates are below the Medicaid</p>	<p>VillageCareMAX has leveraged the findings from the Department of Health's analysis to inform our internal quality assurance and performance improvement program. Monthly meetings are set with each department to review quality measures and troubleshoot any risk areas. Tracking and data analysis is conducted by VillageCareMAX to ensure members are receiving quality care. If needed, corrective action plans are developed to decrease any risk.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	VillageCareMAX's Response	IPRO'S Assessment of VillageCareMAX's Response
Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
<p>VillageCareMAX should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2023 compliance findings.</p> <p>VillageCareMAX should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.</p>	<p>VillageCareMAX'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 identifies the stakeholders responsible for ensuring compliance with the standards. The metrics are reported to the quality management improvement committee on a quarterly basis. When goals are not met, a corrective action plan is required, and the quality management department follows the corrective action plan through to completion to ensure that goals are met.</p>	Addressed.
Network Adequacy		
It is recommended VillageCareMAX continue to pursue provider contracts to expand their provider network.	VillageCareMAX's network team regularly pursues new provider contracts to expand our provider network.	Addressed.
Quality-of-Care Survey		
VillageCareMAX should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	VillageCareMAX conducts internal member satisfaction surveys regularly. VillageCareMAX uses internal and regulatory survey data to develop member experience improvement activities. The customer experience steering committee meets every quarter to discuss member experience data and any improvement activities. The member advisory committee meets quarterly to address member's concerns and feedback.	Addressed.

Performance Improvement Project Summaries and Results

Table 232: VillageCareMAX's Performance Improvement Project Summary, 2024

VillageCareMAX's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By December 2025, VillageCareMAX aims to increase the percentage of members reporting no depressive feelings from 76.00% to 80.00%.▪ By December 2025, VillageCareMAX aims to monitor and track members reporting depressive feelings and had a follow-up positive depression screening through quality metric dashboards.▪ By December 2025, VillageCareMAX aims to ensure members with a positive depression screen have a documented intervention within two weeks of completing the Patient Health Questionnaire-9 Screening Tool.▪ By December 2025, VillageCareMAX aims to increase the percentage of members with a follow up within 60 days of a positive depression screening to 75.00%.
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Created electronic dashboards to track Patient Health Questionnaire-9 Screening Tool completion for continuously enrolled members.▪ Provided trainings to the social work team on available community resources and the integration of www.findhelp.com into guiding care.▪ Administered a quarterly post-training competency test to the social work team requiring a passing score of 80%.
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Care managers educated members during their monthly calls on the importance of depression screening and the resources available to assist members into care.

Table 233: VillageCareMAX’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	75.66%	76.26%	80.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	5.69%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	0.00%	93.29%	75.00%
Percentage of positive depression screens with follow-up	0.00%	81.08%	75.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 234: VillageCareMAX’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	85%	83%	83%	71%
No Severe Daily Pain	100%	99%	99%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	78%	79%	78%	78%
Pneumococcal Vaccination	78%	80%	82%	83%
COVID-19 Vaccination	Not Available	84%	85%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 235: VillageCareMAX’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Comprehensive	2023 Focused ²	2024 Not Yet Available
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	C	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	C	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	C	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	C	C	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	C	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	NC	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	C	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	C	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	C	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	NC	NC	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	C	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	C	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	C	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	C	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 236: VillageCareMAX's Network Gaps, 2024

VillageCareMAX Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care			1	1			1	1								
Audiology Services							1									
Optometry				1												
Oral Surgery							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.

Strengths, Opportunities for Improvement, and Recommendations

Table 237: VillageCareMAX’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VillageCareMAX’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Three of four performance improvement project indicator rates reported by VillageCareMAX demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of three performance improvement project indicator rates reported by VillageCareMAX exceeded their target goals.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for VillageCareMAX for measurement year 2024 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	VillageCareMAX met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of three performance improvement indicator rates did not meet VillageCareMAX’s target rate.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for VillageCareMAX for measurement year 2024 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	VillageCareMAX 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VillageCareMAX 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	VillageCareMAX 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, VillageCareMAX 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	VillageCareMAX 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 VillageCareMAX pursue provider contracts to reduce the gaps identified in their Statement of Agreement when the provider type(s) is available in the		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	county identified in the Statement of Agreement.			

VNS Health Choice

Partial Capitation

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 238: VNS Health Choice’s Response to the 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	VNS Health Choice MLTC’s Response	IPRO’S Assessment of VNS Health MLTC’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 screens all members for social determinants of health upon enrollment and annually to identify needs, connect members to resources and assess intervention impact. Intervention effectiveness is monitored through annual reassessments and outcome tracking. Collaboration with care management teams and providers reinforces the importance of screening, correct coding and ensuring resource connections, such as over-the-counter benefits and post hospital home delivered meals. Screening results also guide updates to care management tools and resources.</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. 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</p>	<p>VNS Health MLTC monitors its performance across the quality measures through current dashboards. Measure-level goals are established annually and are included in the annual quality workplan. VNS Health reviews performance and initiatives in a monthly workgroup and in the quality improvement committee. If performance falls below the statewide average or is not meeting the established goal, VNS Health develops and implements specific interventions to address the measure to improve upon quality of care.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	VNS Health Choice MLTC's Response	IPRO'S Assessment of VNS Health MLTC's Response
Medicaid Managed Long-term Care program mean.		
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 2023 compliance findings. VNS Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	VNS Health maintains policies and practices that support compliance with federal Medicaid standards, including provider credentialing, network adequacy, timely access to services, and enrollee assessments. These combined efforts ensure members receive coordinated, high-quality care aligned with regulatory requirements.	Partially addressed.
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.	The network development team of VNS Health meets weekly to review network adequacy, identify targeted providers, and explore lead generation sources. VNS Health will continue to monitor the network for compliance to ensure our members have appropriate access to care. Most deficiencies in the downstate region have been resolved, and we will continue to address any remaining gaps as needed.	Addressed.
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.	VNS Health administers an interim member satisfaction survey to get additional insights from members on areas that may be underperforming. This survey is administered every year, and VNS Health uses the data to identify targeted improvement opportunities. Initiatives are then designed and implemented to improve member satisfaction and experience.	Addressed.

Performance Improvement Project Summaries and Results

Table 239: VNS Health Choice’s Performance Improvement Project Summary, 2024

VNS Health Choice’s Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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">▪ By the end of 2025, VNS Health Choice aims to increase the percentage of continuously enrolled members that report no depressive feelings by eight percentage points▪ By the end of 2025, VNS Health Choice aims to increase the percentage of continuously enrolled members that report depressive feelings and had a follow-up depression screening by 30.00%▪ By the end of 2025, VNS Health Choice aims to increase the percentage of continuously enrolled members that have a documented intervention within two weeks of a positive screening by 75.00%.▪ By the end of 2025, VNS Health Choice aims to increase the percentage of continuously enrolled members who received a follow up within 60 days of a positive depression screening by 60.00%.
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Care managers received an initial training on the workflows for performance indicators, the Patient Health Questionnaire-9 screening assessment, how to accurately assess members for depressive symptoms, and how to identify recommended interventions based off screening scores.▪ The care management team received additional educational resources via Healthify and the Knowledge Platform to support them in providing education and linking members to community resources and services not covered by VNS Health Choice.
<p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Collaborated with behavioral health specialists to provide educational events to engage with members and provide culturally relevant behavioral health literacy in the community.▪ Created provider education shared via Provider E-Newsletters, during on-site meetings, and provider portal updates that addressed the importance of screening for depressive symptoms, as well as highlighting covered and non-covered benefits and resources that address depressive symptoms.
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ VNS Health Choice created and published member education highlighting the impact depression may have on their overall health, covered and non-covered benefits, and resources that address and improve depressive symptoms in their Member Newsletter.▪ Presented at Member Advisory Council meetings to provide education to members, highlighting the impact depression may have on their overall health and available resources.

Table 240: VNS Health Choice’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	87.33%	84.90%	95.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	0.31%	30.00% ¹
Percentage of positive depression screens that have a documented intervention	0.00%	59.09%	75.00%
Percentage of positive depression screens with follow-up	0.00%	19.70%	60.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 241: VNS Health Choice Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	87%	84%	89%	71%
No Severe Daily Pain	99%	99%	99%	96%
Pain Controlled	97%	98%	98%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	75%	78%	82%	78%
Pneumococcal Vaccination	80%	86%	92%	83%
COVID-19 Vaccination	Not Available	84%	90%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 242: VNS Health Choice’s Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2022 Focused ¹	2023 Focused ²	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	NC
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	Not Reviewed	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	NC
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	C	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	Not Reviewed	Not Reviewed

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.

¹ Appeals and Fair Hearing Focused Survey.

² Provider Network Delivery System Focused Survey.

³ Self Disclosure Focused Survey.

Table 243: VNS Health Choice’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
VNS Health Choice failed to ensure its enrollees received the right to procedural due process and right to fair hearing by failing to send required notices within the specified timeframes as demonstrated by VNS Health Choice’s notification to the Department of Health regarding VNS Health Choice’s self-disclosed system issue between VNS Health Choice’s internal system and the VNS Health mailing vendor, Command Direct, where 2267 decision letters were never sent to members, as required. This included approvals, extensions, acknowledgments, and denials where the members did not receive the right to appeal and Fair Hearing rights.	Partial Capitation Contract Appendix K	438.100, 438.210

Network Adequacy Results

Table 244: VNS Health Choice’s Network Gaps, 2024

VNS Health Choice Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	11	8	8	12	3	5	5	5	1				2	3	2	
Audiology Services	14	15	14	15		3	3	3								
Certified Home Health	1	1			2	1	3	5								
Certified Home Health: Home Based Medical Social Services	1	1		3	9	6	8	5								
Certified Home Health: Home Based Occupational Therapy	1	1		1	3	2	3	4								
Certified Home Health: Home Based Physical Therapy	1	1			5	3	5	7								
Certified Home Health: Home Based Speech Therapy	1	1	1	1	3	1	2	4								
Fiscal Intermediary	9	9			2	4							2			
General Dentistry	2	4	2	3	3	2	4	3								
Institutional Long Term Care					4	4	3	3								
Institutional Long Term Care (AIDS Skilled Nursing Facility)		1	1	1					1							
Institutional Long Term Care (Vent Skilled Nursing Facility)	2	1	1	1	2	3	1	2	1				1			
Institutional Short Term Care					3	3	2	2								
Licensed Home Health Care: Home Based Medical Social Services	15	12	7	16	10	12	14	8								
Licensed Home Health Care: Home Based Occupational Therapy	1	1	1	1	13	13	15	15								
Licensed Home Health Care: Home Based Physical Therapy	1	1	1	1	12	11	13	13								

VNS Health Choice Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Speech Therapy	1	1	1	1	13	13	15	15								
Optometry	2	2		3	1	1	2	1								
Oral Surgery	6	6	7	11	3	2	3	3			1					
Podiatry	11	11	11	13	6	5	5	4								
Social Day Care	7	5	5	6	5	4	4	2	1				3	1		
Telehealth	20	22	21	26	1	1	2	3	2	1	2		5	4	4	
Therapy: Occupational	6	3	3	4		2	2									
Therapy: Physical	2	1	2	3			1									
Therapy: Speech and Language	5	3	2	4		2	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 245: VNS Health Choice’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VNS Health Choice’s performance improvement project for the Partial Capitation population passed validation for measurement year 2024.			
	Two of four performance improvement project indicator rates reported by VNS Health Choice demonstrated improvement and one was maintained between measurement years 2023 and 2024.	X	X	X
Performance Measures	All seven performance measure rates calculated by the Department of Health for VNS Health Choice for measurement year 2024 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 Choice met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates reported by VNS Health Choice demonstrated decline between measurement years 2023 and 2024. All four performance improvement indicator rates did not meet VNS Health Choice’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2024 review, VNS Health Choice was not in full compliance with two standards of 42 Code of Federal Regulations Part 438.	X	X	X
Network Adequacy	VNS Health Choice 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		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	county identified in the Statement of Agreement.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VNS Health Choice 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	VNS Health Choice 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 Choice 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 Choice 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 Choice 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

ArchCare Senior Life

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 246: ArchCare Senior Life’s Response to 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	ArchCare Senior Life’s Response	IPRO’S Assessment of ArchCare Senior Life’s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, ArchCare Senior Life 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>ArchCare Senior Life continues to monitor the progress of our social determinants of health project. A recent barrier analysis confirmed our highest-impact intervention: comprehensive screening across all social determinants of health domains achieved a 99% success rate, exceeding the 75% goal. In line with IPRO feedback, a low-impact intervention (social work analyzer training) was retired and replaced with a more efficient electronic medical record integrated tool. ArchCare Senior Life will continue to adjust interventions based on impact and analysis.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>ArchCare Senior Life 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 Senior Life should focus on enhancing areas of care where its rates are below</p>	<p>ArchCare Senior Life has expanded member engagement strategies, enhanced provider training and targeted key areas for improvement. Ongoing monitoring supports this work. A preventative health service report is generated weekly and shared with the interdisciplinary team, flagging participants due for preventative services. On a monthly basis, ad hoc Uniform Assessment System reports are also reviewed and shared to help identify any gaps in care. These efforts help inform and strengthen our quality improvement program.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	ArchCare Senior Life's Response	IPRO'S Assessment of ArchCare Senior Life's Response
the Medicaid Managed Long-term Care program mean		
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
ArchCare Senior Life 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.	To support readiness for Center of Medicare and Medicaid Services and Department of Health compliance review, ArchCare Senior Life quality improvement and compliance committees meet quarterly to assess service delivery, care quality, regulatory compliance, and ArchCare Senior Life performance. Staff training is provided to ensure awareness and knowledge reinforcement of the regulatory requirements and mandates/guideline updates. In addition, Health Insurance Portability and Accountability Act and compliance training are done upon start of employment and annually.	Addressed.
Network Adequacy		
It is recommended ArchCare Senior Life 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.	ArchCare Senior Life reviews all deficiencies to determine if gaps are due to lack of contracts or data issues. With one exception, all have been due to data submission challenges. ArchCare Senior Life has focused on improving data integration from multiple sources to ensure accurate provider network data system submissions. These efforts have led to significant improvements; ArchCare Senior Life continues to refine processes to reflect its robust provider network.	Addressed.
Quality-of-Care Survey		
ArchCare Senior Life should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	In 2024, ArchCare Senior Life launched the Net Promoter Score Initiative to gauge customer satisfaction, focusing on quality, timeliness, and access. A committee was formed to oversee this	Addressed.

2023 External Quality Review Recommendation	ArchCare Senior Life's Response	IPRO'S Assessment of ArchCare Senior Life's Response
	<p>initiative, which aligns with the Managed Long-Term Care Member Satisfaction Survey administered by IPRO and the New York State Department of Health. Many questions in ArchCare Senior Life's internal Net Promoter Score Survey closely mirror those in the state survey, supporting consistency in evaluating member experience ahead of the New York State Department of Health survey in 2025.</p>	

Performance Improvement Project Summaries and Results

Table 247: ArchCare Senior Life's Performance Improvement Project Summary, 2024

ArchCare Senior Life's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</p> <p>Validation Summary: There were no validation findings that indicate that 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"> ▪ By the end of 2025, ArchCare Senior Life aims to have 94.00% of members reporting no depressive feelings during routine depression screening. ▪ By the end of 2025, ArchCare Senior Life aims to identify and track the percentage of continuously enrolled members who reported depressive feelings on the Uniform Assessment System Community Health Assessment and have had a follow-up positive depression screen using the Patient Health Questionnaire-9 screening tool. ▪ By the end of 2025, ArchCare Senior Life aims to increase documented interventions within two weeks after a positive depression screening from 0% at baseline to 15.00% for all continuously enrolled members. ▪ By the end of 2025, ArchCare Senior Life aims to increase follow up within 60 days of a positive depression screening to 15.00% for all continuously enrolled members. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Conducted semi-annual in-service training for staff on effective administration and coding of Patient Health Questionnaire-9 responses to ensure accurate depression screening. Trained social work staff to use the electronic medical records system for administering the Patient Health Questionnaire-9 depression screening tool. ▪ Developed and implemented a workflow for effectively capturing timely follow-up of all positive depression screens, interventions, and follow-up.

Table 248: ArchCare Senior Life’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	94.76%	95.66%	94.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	0.00%	33.33%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	0.00%	40.00%	15.00%
Percentage of positive depression screens with follow-up	0.00%	20.00%	15.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 249: ArchCare Senior Life’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	87%	85%	85%	71%
No Severe Daily Pain	100%	98%	98%	96%
Pain Controlled	99%	98%	99%	98%
Not Lonely and Distressed	99%	99%	99%	99%
Effectiveness of Care				
Influenza Vaccination	86%	85%	85%	78%
Pneumococcal Vaccination	88%	85%	80%	83%
COVID-19 Vaccination	Not Available	83%	77%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 250: ArchCare Senior Life’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	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed
438.206: Availability of Services	NC	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed
438.236: Practice Guidelines	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	NC

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.

¹ Provider Network Delivery System Focused Survey.

² Performance Improvement Project Focused Survey.

Network Adequacy Results

Table 251: ArchCare Senior Life’s Network Gaps, 2024

ArchCare Senior Life Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Institutional Long Term Care (Vent Skilled Nursing Facility)				1				1								
Oral Surgery								1								
Primary Care Providers							2	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 252: ArchCare Senior Life Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ArchCare Senior Life’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2024.			
	Three of four performance improvement project indicator rates reported by ArchCare Senior Life demonstrated improvement and one maintained between measurement years 2023 and 2024. All three performance improvement project indicator rates exceeded ArchCare Senior Life’s target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for ArchCare Senior Life for measurement year 2024 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 Senior Life met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	ArchCare Senior Life 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.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ArchCare Senior Life 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	ArchCare Senior Life 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 Senior Life 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 Senior Life 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 Senior Life 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

Catholic Health-LIFE

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 253: Catholic Health-LIFE’s Response to 2023 External Quality Review Recommendations

2023 External Quality Review Recommendation	Catholic Health-LIFE’s Response	IPRO’S Assessment of Catholic Health-LIFE ‘s Response
Validation of Performance Improvement Projects		
<p>In the ongoing performance improvement project, Catholic Health-LIFE 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-LIFE had a low percentage of participants with a positive social determinant of health assessment. All participants are screened for social determinants of health at enrollment, at six-month assessment periods and whenever a need arises. A primary care provider, social worker and registered nurse assess all participants every six months. All Catholic Health-LIFE's participants have a monthly registered nurse visit in addition to periodic social work calls and visits.</p>	<p>Addressed.</p>
Validation of Performance Measures		
<p>Catholic Health-LIFE 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-LIFE should focus on enhancing areas of care where its rates are below</p>	<p>Twenty-one percent of our population have both chronic obstructive pulmonary disease and congestive heart failure, 46% have congestive heart failure (25% congestive heart failure without chronic obstructive pulmonary disease) and 35% have chronic obstructive pulmonary disease (14% without congestive heart failure). These participants are managed by our primary care providers and the many specialists we contract with. Many have chronic shortness of breath and are functional with activities of daily living. Regarding pain control, we improved</p>	<p>Partially Addressed.</p>

2023 External Quality Review Recommendation	Catholic Health-LIFE's Response	IPRO'S Assessment of Catholic Health-LIFE 's Response
the Medicaid Managed Long-term Care program mean.	significantly from 2022 to 2023 and continue to offer many modalities for pain control. The percentage of not lonely or distressed members has increased greatly. Members attend the Day Center and use their Grandpad (tablet device designed for seniors).	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards		
Catholic Health-LIFE 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-LIFE has a comprehensive compliance plan which includes setting standards of conduct, written policies and procedures, training, and education, monitoring and safeguards, and oversight by a compliance officer and committee. Monitoring and auditing are performed monthly.	Addressed.
Network Adequacy		
It is recommended Catholic Health-LIFE continue to pursue provider contracts to expand their provider network.	Catholic Health-LIFE has a robust provider network that meets New York State Department of Health regulatory requirements for Program of All-Inclusive Care for the Elderly programs and continues to expand the network as needed.	Partially Addressed.
Quality-of-Care Survey		
Despite its small sample size for the member satisfaction survey, Catholic Health-LIFE should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Catholic Health-LIFE annually surveys member satisfaction via the Integrated Satisfaction Measurement for Program of All-Inclusive Care for the Elderly plans. Our overall satisfaction was 93% in 2024. There are two clinics staffed with at least two providers daily who provide quality care. All members have access to on-call after hours. The nurse on-call can triage and consult with the primary care provider team to determine the necessary care needed.	Addressed.

Performance Improvement Project Summaries and Results

Table 254: Catholic Health-LIFE’s Performance Improvement Project Summary, 2024

Catholic Health-LIFE’s Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
Validation Summary: There were no validation findings that indicate that 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"> By the end of 2025, Catholic Health-LIFE aims to increase the percentage of members with no depressive feelings to 90.00%. By the end of 2025, Catholic Health-LIFE aims to decrease the percentage of members reporting depressive feelings who had a follow-up positive depression screening. By the end of 2025, Catholic Health-LIFE aims to increase the rate of members who had a documented intervention within two weeks of a positive depression screening to 95.00%. By the end of 2025, Catholic Health-LIFE aims to increase the percentage of members with a follow up within 60 days of a positive depression screening to 95.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> Developed workflows for connecting members to counseling services in a timely manner and ensured transportation availability for members. Worked with behavioral health providers to obtain counseling reports to promote continuity of care. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> Offered telehealth appointments for members who were not interested in in-person counseling. Offered Day Center utilization to increase socialization and alleviate loneliness.

Table 255: Catholic Health-LIFE’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	85.03%	89.82%	90.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	32.35%	47.06%	50.00% ¹
Percentage of positive depression screens that have a documented intervention	90.91%	100.00%	95.00%
Percentage of positive depression screens with follow-up	90.91%	100.00%	95.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 256: Catholic Health-LIFE’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	44%	44%	45%	71%
No Severe Daily Pain	96%	96%	93%	96%
Pain Controlled	82%	91%	88%	98%
Not Lonely and Distressed	89%	94%	95%	99%
Effectiveness of Care				
Influenza Vaccination	93%	94%	90%	78%
Pneumococcal Vaccination	89%	87%	76%	83%
COVID-19 Vaccination	Not Available	98%	91%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 257: Catholic Health-LIFE’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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 258: Catholic Health-LIFE’s Network Gaps, 2024

Catholic Health-LIFE Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Clinical Psychology, Psychology							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													
Telehealth					1		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.

Strengths, Opportunities for Improvement, and Recommendations

Table 259: Catholic Health-LIFE’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Catholic Health-LIFE’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2024.			
	All four performance improvement project indicator rates reported by Catholic Health-LIFE demonstrated improvement between measurement years 2023 and 2024. Two of four performance improvement project indicator rates exceeded Catholic Health- LIFE’s 2024 target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Catholic Health-LIFE for measurement year 2024 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-LIFE met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement indicator rates did not meet Catholic Health-LIFE’s target rates.	X	X	X
Performance Measures	Three performance measure calculated by the Department of Health for Catholic Health-LIFE for measurement year 2024 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	Catholic Health-LIFE 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
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Catholic Health-LIFE 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-LIFE 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-LIFE 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-LIFE pursue provider contracts to reduce the gaps 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.			

CenterLight

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 260: CenterLight’s Response to 2023 External Quality Review Recommendations

2023 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 conducts social determinants of health assessments at the start of care and every six months, with electronic medical record alerts to ensure timely completion. The interdisciplinary team reviews interventions biannually or with changes in condition. Ongoing initiatives in 2024 include refresher trainings, case audits, and workflow refinements to address barriers. The goal is to sustain greater than 95% completion and strengthen impact of interventions.</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 access to care, or experienced unfavorable health outcomes. To address this, CenterLight should focus on enhancing areas of care where its rates are</p>	<p>Current data shows CenterLight improved its pneumococcal vaccination rate to 89.1%, a 31% improvement from measurement year 2023. This also exceeds the 88% goal we previously set. Ongoing interventions include monthly care gap reporting, Uniform Assessment System for New York training for staff, and participant education and reminders. Rates are tracked through dashboards and quality reports monthly.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	CenterLight's Response	IPRO'S Assessment of CenterLight's Response
below the Medicaid Managed Long-term Care program mean.		
Review of Compliance with Medicaid and Children's Health Insurance Program 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.	CenterLight promotes audit readiness through mock surveys. Staff are assessed on policies, roles, and regulations. Post-interview feedback and monitoring identify risks. The compliance and quality improvement committees meet quarterly to address findings. Internal reviews are ongoing to ensure readiness for Center of Medicare and Medicaid Service compliance reviews.	Addressed.
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.	CenterLight restructured its provider network and data management team, resolving all deficiencies as of the fourth quarter of 2024 perioperative nursing data set submission. Ongoing internal reviews and quarterly perioperative nursing data set updates are conducted to ensure continued network adequacy and compliance with provider availability standards.	Addressed.
Quality-of-Care Survey		
CenterLight should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	To improve low-rated areas in the Managed Long-term Care Member Satisfaction Survey (care manager, transportation, and dental services), CenterLight implemented participant and staff education, clarified that the Interdisciplinary team is their care manager, worked with the transportation vendor, and replaced the dental vendor. Effectiveness is monitored through complaints, appeals, and internal satisfaction data.	Addressed.

Performance Improvement Project Summaries and Results

Table 261: CenterLight’s Performance Improvement Project Summary, 2024

CenterLight’s Performance Improvement Project Summary	
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members	
Validation Summary: There were no validation findings that indicate that credibility was at risk for the performance improvement project results.	
Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly	
<u>Aims</u>	
<ul style="list-style-type: none">▪ By the end of 2025, CenterLight aims to increase the percentage of participants reporting “no depressive feelings” on the Uniform Assessment System Community Health Assessment by 10.30%.▪ During the duration of the performance improvement project, CenterLight aims to monitor the correlation between the percentage of continuously enrolled participants reporting depressive feelings on the Uniform Assessment System Community Health Assessment and the corresponding results of the Patient Health Questionnaire-9 screening assessments.▪ By the end of 2025, CenterLight aims to increase the percentage of continuously enrolled participants with a positive Patient Health Questionnaire-9 depression screening that have a documented intervention within 2 weeks of the screening by 6.80%.▪ By the end of 2025, CenterLight aims to increase the percentage of continuously enrolled participants with positive depression screening results from the Patient Health Questionnaire-9 that are subsequently followed up within 60 days by 27.10%.	
<u>Managed Care Plan-Focused 2024 Interventions</u>	
<ul style="list-style-type: none">▪ Developed a tracking tool to monitor referrals and appointment follow-through for participants identified with depression.▪ Created a reporting system to quantify completed assessments, positive Patient Health Questionnaire-9 screening scores, and corresponding interventions, enabling progress tracking and barrier identification.▪ Delivered comprehensive training to social work staff and interdisciplinary team members on Patient Health Questionnaire-9 screening administration, sensitive communication, documentation, and follow-up procedures, including cultural and clinical considerations.▪ Administered a competency exam to trained staff, requiring a minimum passing score of 80.00% to ensure proficiency.	
<u>Member-Focused 2024 Interventions</u>	
<ul style="list-style-type: none">▪ Educated participants on the importance of honest Patient Health Questionnaire-9 screening responses through accessible materials and outreach, using a “teach-back” method to confirm understanding.	

Table 262: CenterLight’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	81.26%	88.38%	89.60%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	14.26%	28.92%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	90.11%	97.57%	85.60%
Percentage of positive depression screens with follow-up	73.91%	98.28%	75.60%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 263: CenterLight’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	91%	95%	98%	71%
No Severe Daily Pain	100%	99%	99%	96%
Pain Controlled	99%	99%	99%	98%
Not Lonely and Distressed	99%	100%	100%	99%
Effectiveness of Care				
Influenza Vaccination	85%	89%	93%	78%
Pneumococcal Vaccination	67%	68%	84%	83%
COVID-19 Vaccination	Not Available	91%	95%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 264: 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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 265: CenterLight’s Network Gaps, 2024

CenterLight Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	2	1	1													
Audiology Services						1	1									
Certified Home Health							3									
Institutional Long Term Care (AIDS Skilled Nursing Facility)			1		1	2	1									
Social Day Care		1	1													
Social and Environmental Support		1	2			1										
Telehealth							1									
Transportation (Ambulance Services)					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.

Strengths, Opportunities for Improvement, and Recommendations

Table 266: 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 2024.			
	All four performance improvement project indicator rates reported by CenterLight demonstrated improvement between measurement years 2023 and 2024. Two of three performance improvement project indicator rates exceeded CenterLight’s target rates.	X	X	X
Performance Measures	Six performance measure rates calculated by the Department of Health for CenterLight for measurement year 2024 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
Opportunities for Improvement				
Performance Improvement Project	One of three performance improvement indicator rate did not meet CenterLight’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
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

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

Complete Senior Care

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 267: Complete Senior Care’s Response to 2023 External Quality Review Recommendations

2023 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>The social workers at Complete Senior Care restarted the Center of Medicare and Medicaid Services Social Needs Screening Tool in 2024 and were able to begin screening our participants during their assessments. By the end of 2024, we had a good process in place, with a goal to get all participants screened by the end of 2025.</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 care where its rates are below</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>

2023 External Quality Review Recommendation	Complete Senior Care's Response	IPRO'S Assessment of Complete Senior Care's Response
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, Title 42 Code of Federal Regulations 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.
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.	Complete Senior Care pursues provider contracts as needed. Our current gap related to certified home health and licensed home health care agencies has been rectified. We are contracted with four agencies that provide home health aide and personal care aide services, along with public partnerships that provides our personal assistant services. We are contracted with two agencies that provide home based occupational therapy, physical therapy, speech therapy and private duty nursing.	Addressed.
Quality-of-Care Survey		
Despite its small sample size for the member satisfaction survey, Complete Senior Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Complete Senior Care monitors complaints and grievances daily. We have small surveys through the Day Center as needed. We respond appropriately to grievances and track trends throughout the year.	Addressed.

Performance Improvement Project Summaries and Results

Table 268: Complete Senior Care’s Performance Improvement Project Summary, 2024

Complete Senior Care’s Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
Validation Summary: There were no validation findings that indicate that credibility was at risk for the performance improvement project results.
Medicaid Managed Care Population: Program of All-Inclusive Care for the Elderly
<u>Aims</u>
<ul style="list-style-type: none">▪ By the end of 2025, Complete Senior Care aims to increase the percentage of continuously enrolled members with no depressive feelings to 65.00%.▪ By the end of 2025, Complete Senior Care aims to ensure continuously enrolled members reporting depressive feelings have had a follow-up positive depression screening in a timely manner.▪ By the end of 2025, Complete Senior Care aims to have 80.00% of its continuously enrolled members have a documented intervention within two weeks of a positive depression screening.▪ By the end of 2025, Complete Senior Care aims to have 80.00% of its continuously enrolled members with a positive depression screening to have a follow up within 60 days.
<u>Managed Care Plan-Focused 2024 Interventions</u>
<ul style="list-style-type: none">▪ Created an electronic follow-up notification alerting social workers when participants who indicated depressive feelings on the Uniform Assessment System Community Health Assessment and were not receiving treatment for depression.▪ Educated staff members quarterly that all participants are to undergo a Uniform Assessment System Community Health Assessment screening. If a participant indicates depressive feelings, enhanced depression follow-up protocol should take place.▪ The Director of Quality reviewed interventions for positive Geriatric Depression Scale -30 questionnaires with social workers and instructed on follow-up needed.

Table 269: Complete Senior Care’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	45.21%	64.71%	65.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	27.78%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	Not Available	80.00%	80.00%
Percentage of positive depression screens with follow-up	Not Available	40.00%	80.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 270: Complete Senior Care’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	25%	23%	24%	71%
No Severe Daily Pain	91%	90%	93%	96%
Pain Controlled	81%	84%	87%	98%
Not Lonely and Distressed	55%	47%	56%	99%
Effectiveness of Care				
Influenza Vaccination	85%	84%	86%	78%
Pneumococcal Vaccination	84%	78%	88%	83%
COVID-19 Vaccination	Not Available	90%	91%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 271: 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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 272: Complete Senior Care’s Network Gaps, 2024

Complete Senior Care Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care						1	1	1	1							
Certified Home Health					1											
Fiscal Intermediary	1	1														
Institutional Long Term Care (Vent Skilled Nursing Facility)									1							
Licensed Home Health Care: Home Based Occupational Therapy	1					1	1	1								
Licensed Home Health Care: Home Based Physical Therapy	1					1	1	1								
Licensed Home Health Care: Home Based Speech Therapy	1					1	1	1								
Nutrition	1															
Oncology and Hematology					1											
Oral Surgery	1															
Personal Emergency Response	1															
Pharmacy					1	1										
Physical Med and Rehabilitation					1	1	1									
Private Duty Nursing					1	1	1									
Telehealth					1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 273: 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 2024.			
	One performance improvement project indicator rate reported by Complete Senior Care demonstrated improvement between measurement years 2023 and 2024. One of three performance improvement project indicator rates met Complete Senior Care’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Complete Senior Care met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Two of three performance improvement indicator rates did not meet Complete Senior Care’s target rate.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Complete Senior Care for measurement year 2024 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	Complete 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
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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

Eddy SeniorCare

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 274: Eddy SeniorCare’s Response to 2023 External Quality Review Recommendations

2023 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 initiated process improvement activities that are embedded in Eddy SeniorCare quality assurance performance improvement plan. Interventions are continuously monitored and reported out quarterly at Eddy SeniorCare’s quality assurance performance improvement committee. Eddy SeniorCare incorporated shared governance concepts when reviewing quality assurance performance improvement plan annually with interdisciplinary team annually to determine strategic aims and priorities when developing new process improvement projects needed or retiring old ones.</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 SeniorCare should focus on enhancing areas of care where</p>	<p>Eddy SeniorCare has incorporated the New York State Department of Health’s health assessment data in quality improvement planning. Immunizations and severe pain control is at or significantly better than the managed long-term care statewide average. Areas of opportunity include “no shortness of breath,” “pain controlled,” “not lonely or not distressed.” These areas where Eddy SeniorCare performed statistically worse than managed long-term care statewide average. These areas have been embedded in quality assurance</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Eddy SeniorCare's Response	IPRO'S Assessment of Eddy SeniorCare's Response
its rates are below the Medicaid Managed Long-term Care program mean.	performance improvement program 2024 and are audited for oversight and reviewed quarterly at quality assurance performance improvement committee.	
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.	At Eddy SeniorCare we have a compliance team that meets to review federal and state Medicaid standards compliance requirements.	Partially Addressed.
Network Adequacy		
It is recommended Eddy SeniorCare 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.	Eddy SeniorCare will continue to work on provider network to address any areas of deficiency identified. The perioperative nursing data set is reviewed and submitted quarterly.	Addressed.
Quality-of-Care Survey		
Eddy SeniorCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Eddy SeniorCare has taken survey results and embedded them into quality assurance performance improvement program to address adverse member experience. These process improvement interventions are reviewed at quarterly quality assurance performance improvement meeting to initiate process improvements in these areas on the next quality of care survey.	Addressed.

Performance Improvement Project Summaries and Results

Table 275: Eddy SeniorCare’s Performance Improvement Project Summary, 2024

Eddy SeniorCare’s Managed Long-Term Care Plan Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
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">▪ By the end of 2025, Eddy SeniorCare aims to increase the percentage of participants reporting no depressive feelings for continuously enrolled participants by 10.00% from baseline measurement year.▪ Eddy SeniorCare will track and trend the percentage of continuously enrolled participants who reported depressive feelings that had a follow-up positive depressive screening.▪ By the end of 2025, Eddy SeniorCare aims to increase the percentage of participants who scored positive on Patient Health Questionnaire-9 Screening Tool and had intervention documented by 10.00% from baseline measurement year.▪ By the end of 2025, Eddy SeniorCare aims to increase the percentage of participants who scored positive on Patient Health Questionnaire-9 Screening Tool and had follow up documented within 60 days by 10.00% from baseline measurement year. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Implemented a standalone depression assessment within Eddy SeniorCare’s electronic medical record.▪ Educated social work staff on specific interventions that correlate to participants’ positive Patient Health Questionnaire-9 screening score.▪ Educated nursing staff on a new communication process for when participants answer yes to depressive symptoms.

Table 276: Eddy SeniorCare’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	79.44%	79.09%	87.34%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	38.98%	83.07%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	52.17%	100.00%	57.42%
Percentage of positive depression screens with follow-up	34.78%	78.95%	38.26%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 277: Eddy SeniorCare’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	50%	45%	48%	71%
No Severe Daily Pain	97%	93%	95%	96%
Pain Controlled	86%	87%	83%	98%
Not Lonely and Distressed	91%	91%	87%	99%
Effectiveness of Care				
Influenza Vaccination	88%	90%	90%	78%
Pneumococcal Vaccination	88%	91%	92%	83%
COVID-19 Vaccination	Not Available	87%	68%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 278: Eddy SeniorCare’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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 279: Eddy SeniorCare’s Network Gaps, 2024

Eddy SeniorCare Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care						1	3		2							
Anesthesiology Services							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.

Strengths, Opportunities for Improvement, and Recommendations

Table 280: Eddy SeniorCare’s Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Eddy SeniorCare’s performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2024.			
	Three of four performance improvement project indicator rates reported by Eddy SeniorCare demonstrated improvement and one was maintained between measurement years 2023 and 2024. Two of three performance improvement project indicator rates exceeded Eddy SeniorCare’s target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for Eddy SeniorCare for measurement year 2024 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 SeniorCare met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of three performance improvement indicator rates did not meet Eddy SeniorCare’s target rates.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Eddy SeniorCare for measurement year 2024 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	None.			
Network Adequacy	Eddy SeniorCare 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
Recommendations				
Performance Improvement Project	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.	X	X	X
Performance Measures	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 SeniorCare 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 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	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Centers for Medicare & Medicaid Services.			
Network Adequacy	It is recommended Eddy SeniorCare 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

ElderONE

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 281: ElderONE’s Response to 2023 External Quality Review Recommendations

2023 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>Partially 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</p>	<p>ElderONE utilizes findings from the Department of Health data to assist in the development of our quality assurance and performance improvement program. ElderONE continues to work towards improving our measured rates to ensure our participants have received optimal 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</p>	<p>Partially Addressed.</p>

2023 External Quality Review Recommendation	ElderONE's Response	IPRO'S Assessment of ElderONE's Response
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.	Care program mean. ElderONE utilizes all feedback from participants.	
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 Center for Medicare & Medicaid Services.	Addressed.
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.	ElderONE continues to review provider contracts to reduce gaps identified in their Statement of Agreement.	Addressed.
Quality-of-Care Survey		
ElderONE should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	At ElderONE, we evaluate member and family satisfaction through our annual participant and family satisfaction survey, which runs for approximately two months. This survey is designed to capture data on the scope of participant experiences, the duration of any reported issues, and the frequency with which they occur. The results help develop our ongoing quality improvement initiatives and	Addressed.

2023 External Quality Review Recommendation	ElderONE's Response	IPRO'S Assessment of ElderONE's Response
	educational pieces to highlight at quality meetings.	

Performance Improvement Project Summaries and Results

Table 282: ElderONE's Performance Improvement Project Summary, 2024

ElderONE's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</p>
<p>Validation Summary: There were no validation findings that indicate that 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"> ▪ By the end of 2025, ElderONE aims to increase the percentage of members reporting no depressive feelings for all continuously enrolled members from 58.73% at baseline to 66.94%. ▪ By the end of 2025, ElderONE aims to track the percentage of continuously enrolled members who self-reported depressive feelings and had a follow-up positive depression screen, this is for tracking purposes only. ▪ By the end of 2025, ElderONE aims to maintain interim results (100.00%) with the percentage of members who had a documented intervention in place within two weeks of a positive depression screen for all continuously enrolled members. ▪ By the end of 2025, ElderONE aims to maintain interim results (100.00%) with the percentage of members with a follow-up assessment within 60 days of an initial positive depression screen for all continuously enrolled members. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Implemented into staff workflow a standardized quality report that identifies follow-up actions when a participant self-report depressive feeling(s). ▪ Created a tracking document to analyze and share screening results for participants that self-reported depressive feelings and had a positive depression screen. ▪ ElderOne developed educational materials with aligned competencies for all participant facing employees to review and complete. Education included types of depression, risk factors, signs and symptoms, treatment, and preventive measures.

Table 283: ElderONE’s Performance Improvement Project Indicator Summary, Measurement Years, 2023 -2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	58.73%	65.55%	66.94%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	34.45%	39.45% ¹
Percentage of positive depression screens that have a documented intervention	Not Available	100.00%	100.00%
Percentage of positive depression screens with follow-up	Not Available	100.00%	100.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 284: ElderONE’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	51%	51%	73%	71%
No Severe Daily Pain	95%	98%	97%	96%
Pain Controlled	92%	96%	97%	98%
Not Lonely and Distressed	94%	96%	92%	99%
Effectiveness of Care				
Influenza Vaccination	84%	84%	82%	78%
Pneumococcal Vaccination	76%	67%	89%	83%
COVID-19 Vaccination	Not Available	80%	70%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 285: 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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 286: ElderONE’s Network Gaps, 2024

ElderONE Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Audiology Services				1				1								
Inpatient Hospital (Medical Inpatient)								1								
Institutional Long Term Care					1			1								
Primary Care Providers					1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 287: 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 2024.			
	One performance improvement project indicator rate reported by ElderONE demonstrated improvement between measurement years 2023 and 2024. Two of four performance improvement project indicator rates met ElderONE’s target rates.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for ElderONE for measurement year 2024 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
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement project indicator rates did not reach ElderONE’s target rates.	X	X	X
Performance Measures	Two performance measure rates calculated by the Department of Health for ElderONE for measurement year 2024 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	ElderONE has the opportunity to reduce their gaps in their network that were identified in their		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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

Fallon Health

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 288: Fallon Health’s Response to 2023 External Quality Review Recommendations

2023 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 has integrated use of social determinants of health into the social work assessment process consistently. Assisted living partnerships as a housing resource have continued to grow and provide a resource for members with housing insecurity. Fallon Health identified the potential to embed behavioral health with the interdisciplinary team as an opportunity to address emotional well-being. A new internal behavioral health clinician position was approved as part of the interdisciplinary team.</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>New York State identified two performance measures as performing statistically worse than the statewide mean. The measure targeting lonely or depressive thoughts is addressed by the ongoing performance improvement project to reduce depression. Fallon Health continues to monitor the effectiveness of interventions and progress towards the established goals. The second measure identified is shortness of breath. Additional quality improvement program activities include standardized interdisciplinary team management of congestive health</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Fallon Health's Response	IPRO'S Assessment of Fallon Health's Response
below the Medicaid Managed Long-term Care program mean.	failure with expected improvement in shortness of breath.	
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 maintains a comprehensive compliance program 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 compliance officer is responsible for monitoring adherence to the compliance plan.	Addressed.
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.	In 2023, Fallon Health made significant strides in strengthening its provider network by proactively addressing service gaps, particularly in skilled nursing and transportation services. Through targeted outreach and strategic collaboration, Fallon Health successfully secured new contracts with high-quality skilled nursing facilities and reliable transportation providers. These efforts not only enhanced access to essential care but also reinforced Fallon Health's commitment to addressing gaps.	Addressed.
Quality-of-Care Survey		
Despite its small sample size for the member satisfaction survey, Fallon Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Fallon Health conducts telephonic satisfaction surveys with newly enrolled and existing members to assess their experiences and identify opportunities for improvement. The program director conducts outreach, gathering additional feedback to enhance service delivery. One example is an update to the network of transportation providers based on survey feedback.	Addressed.

Performance Improvement Project Summaries and Results

Table 289: Fallon Health’s Performance Improvement Project Summary, 2024

Fallon Health’s Managed Long-Term Care Plan Performance Improvement Project Summary
Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members
Validation Summary: There were no validation findings that indicate that 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">• By December 31, 2025, Fallon Health aims to increase the percentage of continuously enrolled eligible participants, reporting no depressive feelings from 63.39% to 97.00%.• By December 31, 2025, Fallon Health will identify the percentage of eligible participants, those enrolled in the measurement year for six months or more, who have reported depressive feelings and have had a follow-up positive depression screen by the Patient Health Questionnaire-9.• By December 31, 2025, Fallon Health aims to increase the percentage of continuously enrolled eligible participants with interventions implemented immediately or within two weeks of the positive screen from 95.56% to 97.50 %.• By December 31, 2025, Fallon Health aims to improve the percentage of continuously enrolled eligible participants with a documented follow up within 60 days of positive screen from 46.67% to 75.00%. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Conducted manual review of member records until Patient Health Questionnaire-9 Screening Tool became available through Fallon Health’s electronic medical record.▪ Improved electronic health record capabilities to allow for Patient Health Questionnaire-9 Screening Tool data to be compiled and extracted for analysis/reporting. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Interdisciplinary team engaged with continuously enrolled members who refused intervention(s) after a positive Patient Health Questionnaire-9 screening.

Table 290: Fallon Health’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	63.39%	45.06%	97.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	84.91%	78.87%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	95.56%	100.00%	97.50%
Percentage of positive depression screens with follow-up	46.67%	41.07%	75.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 291: Fallon Health’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	39%	51%	51%	71%
No Severe Daily Pain	91%	95%	96%	96%
Pain Controlled	76%	93%	89%	98%
Not Lonely and Distressed	92%	93%	96%	99%
Effectiveness of Care				
Influenza Vaccination	72%	80%	66%	78%
Pneumococcal Vaccination	68%	68%	54%	83%
COVID-19 Vaccination	Not Available	93%	75%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 292: 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	2024 Focused ³
438.56: Disenrollment: Requirements and Limitations	Not Reviewed	Not Reviewed	Not Reviewed
438.100: Enrollee Rights	Not Reviewed	Not Reviewed	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed	Not Reviewed	Not Reviewed
438.206: Availability of Services	C	Not Reviewed	Not Reviewed
438.207: Assurances of Adequate Capacity and Services	Not Reviewed	Not Reviewed	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed	Not Reviewed	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed	Not Reviewed	Not Reviewed
438.214: Provider Selection	Not Reviewed	Not Reviewed	Not Reviewed
438.224: Confidentiality	Not Reviewed	Not Reviewed	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed	Not Reviewed	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed	Not Reviewed	NC
438.236: Practice Guidelines	Not Reviewed	Not Reviewed	Not Reviewed
438.242: Health Information Systems	Not Reviewed	Not Reviewed	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed	NC	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

² Performance Improvement Project Focused Survey.

³ Management Services Agreement Focused Survey.

Table 293: Fallon Health’s Compliance Review Summary of Results, 2024

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Fallon Health failed to submit to the Department of Health for approval a new Management Services Agreement at least 90 days prior to the management contract’s proposed effective date.	Program of All-Inclusive Care for the Elderly Contract Article V B.4 Part 98 of New York Codes, Rules, and Regulations Section 98-1.11 (k)	438.230

Network Adequacy Results

Table 294: Fallon Health’s Network Gaps, 2024

Fallon Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care	1	1	1	1							1	1				
Anesthesiology Services	1	1				1										
Certified Home Health			1			1										
Certified or Licensed Home Health Care - Personal Care Assistant						1										
Clinical Psychology, Psychology		1	1	1												
Consumer Directed Personal Care		1	1	1	1	1	1	1								
Endocrinology and Metabolism		1	1	1												
Family Practice		1														
Fiscal Intermediary						1										
Gastroenterology						1	1	1								
General Practice		1														
Geriatrics		1	1	1												
Home Delivered and Congregate Meals	1															
Inpatient Hospital (Medical Inpatient)	1	2						1								
Institutional Long Term Care (AIDS Skilled Nursing Facility)		1														
Institutional Long Term Care (Vent Skilled Nursing Facility)	1	1	1													
Institutional Short Term Care	1	2	2	2												
Internal Medicine		1														
Licensed Home Health Care: Home Based Medical Social Services		1														
Licensed Home Health Care: Home Based Occupational Therapy	1	2														

Fallon Health Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Physical Therapy	1	2														
Licensed Home Health Care: Home Based Speech Therapy	1	2														
Licensed Social Work						1										
Medical Laboratories	1	2														
Neurology		1	1					1								
Neurology Surgery		1	1	1												
Nutrition		1	1	1												
Oral Surgery		1														
Orthopedics						1	1	1								
Otolaryngology		1	1	1												
Personal Emergency Response				2												
Pharmacy	1	1				1		1								
Physical Med and Rehabilitation						1	1	1								
Plastic Surgery		1	1	1												
Primary Care Providers			1	1												
Private Duty Nursing						1										
Psychiatry						1										
Pulmonary Medicine						1	1	1								
Radiology						1	1	1								
Rheumatology		1	1	1												
Social Day Care	1	1				1										
Social and Environmental Support			2	2												
Telehealth	1	2	2	2												
Therapy: Respiratory	1		2	2		1										
Thoracic Surgery	1	1	1	1		1	1	1								
Transportation (Ambulance Services)		1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 295: 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 2024.			
	One of four performance improvement project indicator rates reported by Fallon Health demonstrated improvement between measurement years 2023 and 2024. One of three performance improvement project indicator rates reported by Fallon Health exceeded their target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	Fallon Health met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	Three of four performance improvement project indicator rates reported by Fallon Health demonstrated a performance decline between measurement years 2023 and 2024. Two of three performance improvement project indicator rates did not reach Fallon Health’s target rates.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Fallon Health for measurement year 2024 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	During the 2024 review, Fallon Health was not in full compliance with one standard of 42 Code of Federal Regulations.	X	X	X
Network Adequacy	Fallon Health has the opportunity to reduce their gaps in their network that were identified in		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.			
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

PACE CNY

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 296: PACE CNY’s Response to 2023 External Quality Review Recommendations

2023 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>During the performance improvement project PACE CNY continued to monitor the progress made towards our established goals, and the effectiveness of current interventions. Modifications were made to interventions as deemed necessary based upon the effectiveness of the intervention.</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</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 is mutually completed with the assistance and approval of the participant/caregiver. These interventions resulted in percentages to remain the same or improved, showing they are effectively improving results.</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	PACE CNY's Response	IPRO'S Assessment of PACE CNY's Response
<p>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.</p>		
<p>Review of Compliance with Medicaid and Children's Health Insurance Program Standards</p>		
<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 departments review all pertinent Centers for Medicare & Medicaid Services audit protocols and health plan management system 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 the Program of All-Inclusive Care for the Elderly. The process for monitoring compliance is conducted through auditing regulatory standards and providing this information to internal and external stakeholders.</p>	<p>Addressed.</p>
<p>Network Adequacy</p>		
<p>It is recommended PACE CNY continue to pursue provider contracts to expand their provider network.</p>	<p>PACE CNY continues to work on building the outside provider network to exceed the federal requirements for network adequacy.</p>	<p>Addressed.</p>
<p>Quality-of-Care Survey</p>		
<p>PACE CNY should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.</p>	<p>PACE CNY showed improvement in two of three areas and one area remained stable, all three were lower than average. Grievances received are addressed, tracked, and trended regarding quality and timeliness per regulations and customer satisfaction surveys are conducted on an annual basis. Network provider expansion is ongoing to increase access to care and quarterly participant satisfaction surveys are conducted for contracted provider visits. The interventions</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	PACE CNY's Response	IPRO'S Assessment of PACE CNY's Response
	resulted in percentages to remain the same or increase.	

Performance Improvement Project Summaries and Results

Table 297: PACE CNY Performance Improvement Project Summary, 2024

PACE CNY's Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</p>
<p>Validation Summary: There were no validation findings that indicate that 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"> ▪ By the end of 2025, PACE CNY aims for at least 70.00% of plan members to report no depressive feelings. ▪ By the end of 2025, PACE CNY aims to accurately monitor and trend the percentage of plan members reporting depressive feelings on the Uniform Assessment System Community Health Assessment that had a follow-up positive depression screen. ▪ By the end of 2025, PACE CNY aims to maintain/increase the percentage of positive depression screens with a documented intervention within 2 weeks for included plan members to $\geq 69.50\%$ (based upon the Healthy People 2030 target for increasing the proportion of adults with depression who get treatment) ▪ By the end of 2025, PACE CNY aims to maintain and/or increase the percentage of positive depression screens with follow-up within 60 days for plan members to $\geq 69.50\%$. (based upon the Healthy People 2030 target for increasing the proportion of adults with depression who get treatment) <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ PACE CNY surveyed social workers on whether they familiarized themselves with the policies, procedures, and resources available on the completion of the Patient Health Questionnaire-9 Screening Tool. ▪ Staff received training in completion of the Uniform Assessment System Community Health Assessment along with a resource manual. ▪ PACE CNY purchased the Lenavi system which provides trainings, presentations, and online courses to assist in Uniform Assessment System Community Health Assessment reporting accuracy. <p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ PACE CNY providers received training on how to use the Patient Health Questionnaire-9 screening tool, and reviewed participants who screened positive for depression to ensure the accuracy of the results.

Table 298: PACE CNY’s Performance Improvement Project Indicator Summary, Measurement Years, 2023 -2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	73.04%	88.10%	70.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	87.10%	80.00%	Target Not Established ¹
Percentage of positive depression screens that have a documented intervention	88.89%	100.00%	≥69.50%
Percentage of positive depression screens with follow-up	100.00%	100.00%	≥69.50%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 299: PACE CNY’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	43%	48%	47%	71%
No Severe Daily Pain	97%	96%	96%	96%
Pain Controlled	95%	95%	94%	98%
Not Lonely and Distressed	88%	92%	97%	99%
Effectiveness of Care				
Influenza Vaccination	83%	83%	83%	78%
Pneumococcal Vaccination	76%	83%	88%	83%
COVID-19 Vaccination	Not Available	84%	75%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 300: PACE CNY’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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 301: PACE CNY's Network Gaps, 2024

PACE CNY Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Licensed Home Health Care: Home Based Occupational Therapy						1	1	1								
Licensed Home Health Care: Home Based Physical Therapy						1	1	1								
Licensed Home Health Care: Home Based Speech Therapy						1	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.

Strengths, Opportunities for Improvement, and Recommendations

Table 302: 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 2024.			
	Two of four performance improvement project indicator rates reported by PACE CNY demonstrated improvement and one was maintained between measurement years 2023 and 2024. All three performance improvement project indicator rates exceeded PACE CNY’s target rates.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Network Adequacy	PACE CNY met the federal requirements for Network Adequacy.		X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance indicator rates reported by PACE CNY did not demonstrate improvement between measurement years 2023 and 2024.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for PACE CNY for measurement year 2024 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	PACE CNY 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.			
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 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

Total Senior Care

Program of All-Inclusive Care for the Elderly

Assessment of Managed Care Plan Follow-up on the 2023 External Quality Review Recommendations

Table 303: Total Senior Care’s Response to 2023 External Quality Review Recommendations

2023 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>At the completion of the performance improvement project, Total Senior Care instituted a newly developed screening tool to assess social determinants of health which better addressed the needs of program members. This tool continues to be utilized for our members at initial enrollment and minimally biannually thereafter. With early detection of potential needs, members will receive improved quality of care which leads to overall improved member satisfaction.</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</p>	<p>In 2024 Total Senior Care's quality improvement plan focused on tracking managed long-term care quality incentive measures to improve standards of participant care. Other areas of focus included fall data tracking, emergency room visit/hospital data, participant satisfaction, infection monitoring, decreasing depression rates among Total Senior Care members, increasing participant</p>	<p>Addressed.</p>

2023 External Quality Review Recommendation	Total Senior Care's Response	IPRO'S Assessment of Total Senior Care's Response
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.	enrollment rates, and medical record and overall program auditing.	
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.	Medical record auditing, plan of care audits, and overall program auditing was completed and continues to occur to assess for any areas needing improvement. In 2024, routine survey readiness meetings were conducted with a survey readiness committee to discuss areas needing improvement and strategies to accomplish this. Staff education surrounding survey preparedness was also completed.	Addressed.
Network Adequacy		
It is recommended Total 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.	We agree with the recommendation to pursue provider contracts to reduce gaps identified in our Statement of Agreement. When provider types are available in the county identified, Total Senior Care pursues a contract with such providers. Network adequacy is important to Total Senior Care.	Addressed.
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	Total Senior Care has a procedure in place to assess member satisfaction via survey at the time of a member's annual assessment. The Activities Director meets with	Partially Addressed.

2023 External Quality Review Recommendation	Total Senior Care's Response	IPRO'S Assessment of Total Senior Care's Response
<p>experience with areas linked to quality, timeliness, and access to care.</p>	<p>the participant and supplies the survey. Members are assisted at their request if needed, and they do have the option to complete the survey anonymously. If a member is unable to complete the survey due to cognitive deficits, the survey is forwarded to a family member in their care circle for completion.</p>	

Performance Improvement Project Summaries and Results

Table 304: Total Senior Care’s Performance Improvement Project Summary, 2024

Total Senior Care’s Performance Improvement Project Summary
<p>Title: Decreasing Rates of Depression among Medicaid Managed Long-Term Care Members</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"> By the end of 2025, Total Senior Care aims to increase the percentage of members reporting no depressive feelings to 63.00%. By the end of 2025, Total Senior Care aims to increase the documentation of members reporting depressive feelings along with a positive follow-up depression screen to 100%. By the end of 2025, Total Senior Care aims to increase the percentage of members with positive depression screens who then have a documented intervention within two weeks of screening to maintain the 100.00% interim measurement year rate. By the end of 2025, Total Senior Care aims to increase the percentage of members with positive Geriatric Depression Scale-15 (screen of five or higher who then have a documented mental health follow-up within 60 days) to maintain the 100.00% interim measurement year rate. <p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> Established a step-by-step protocol for staff to follow from beginning of assessment implementation through connecting pertinent plan members to mental health services in a timely manner.

Table 305: Total Senior Care’s Performance Improvement Project Indicator Summary, Measurement Years, 2023-2024

Measure	Baseline Measurement Year 2023	Interim Measurement Year 2024	Target
Percentage of members reporting no depressive feelings	14.57%	60.91%	≥63.00%
Percentage of members reporting depressive feelings and had a follow-up positive depression screen	Not Available	48.84%	100.00% ¹
Percentage of positive depression screens that have a documented intervention	Not Available	100.00%	100.00%
Percentage of positive depression screens with follow-up	Not Available	100.00%	100.00%

¹ Plans could choose to select a target for this indicator, but it was not required. This performance indicator was intended to be used to monitor/trend (informational measure only).

Performance Measure Results

Table 306: Total Senior Care’s Performance Measure Results, Measurement Years 2022 to 2024

Measure Description	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024	Statewide Managed Long-Term Care Average 2024
Preventive Care				
No Shortness of Breath	52%	51%	43%	71%
No Severe Daily Pain	80%	82%	87%	96%
Pain Controlled	89%	78%	80%	98%
Not Lonely and Distressed	69%	75%	65%	99%
Effectiveness of Care				
Influenza Vaccination	66%	69%	86%	78%
Pneumococcal Vaccination	65%	68%	88%	83%
COVID-19 Vaccination	Not Available	83%	80%	80%

¹Managed 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 2024 performance is statistically significantly better than the Managed Long-Term Care statewide 2024 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 2024 performance is statistically significantly worse than the Managed Long-Term Care statewide 2024 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 307: 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	Not Reviewed
438.100: Enrollee Rights	Not Reviewed
438.114: Emergency and Poststabilization Services	Not Reviewed
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	Not Reviewed
438.208: Coordination and Continuity of Care	Not Reviewed
438.210: Coverage and Authorization of Services	Not Reviewed
438.214: Provider Selection	Not Reviewed
438.224: Confidentiality	Not Reviewed
438.228: Grievance and Appeal System	Not Reviewed
438.230: Subcontractual Relationships and Delegation	Not Reviewed
438.236: Practice Guidelines	Not Reviewed
438.242: Health Information Systems	Not Reviewed
438.330: Quality Assessment and Performance Improvement Program	Not Reviewed

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.

¹ Provider Network Delivery System Focused Survey.

Network Adequacy Results

Table 308: Total Senior Care’s Network Gaps, 2024

Total Senior Care Network Gaps, 2024																
Provider Type With A Gap ¹	County Access				County Choice				Surrounding Area Access				Surrounding Area Choice			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Day Health Care							1			2						
Certified Home Health								2								
Clinical Psychology, Psychology						1	1									
Dermatology					2	2	1	1			1					
Endocrinology and Metabolism								1	1	1	1					
Institutional Long Term Care				1			1									
Institutional Long Term Care (Vent Skilled Nursing Facility)									1							
Institutional Short Term Care				1			1									
Licensed Home Health Care: Home Based Medical Social Services							1	1								
Medical Laboratories								1								
Neurology								1								
Neurology Surgery			2	1		1			1				1			
Oncology and Hematology								1								
Oral Surgery			1	1		1			1							
Otolaryngology						1										
Pharmacy						1										
Physical Med and Rehabilitation					1	1	1									
Plastic Surgery				1	1					1	1					
Telehealth									1							
Transportation (Ambulance Services)			1		1											
Urology			1			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.

Strengths, Opportunities for Improvement, and Recommendations

Table 309: 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 2024.			
	One performance improvement project indicator rate reported by Total Senior Care demonstrated improvement between measurement years 2023 and 2024. Two of four performance improvement project indicator rates met Total Senior Care’s 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
Opportunities for Improvement				
Performance Improvement Project	Two of four performance improvement project indicator rates did not reach Total Senior Care’s target rates.	X	X	X
Performance Measures	Four performance measure rates calculated by the Department of Health for Total Senior Care for measurement year 2024 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	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
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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 in their Statement of Agreement when the provider type(s) is available in the county identified in the Statement of Agreement.		X	X

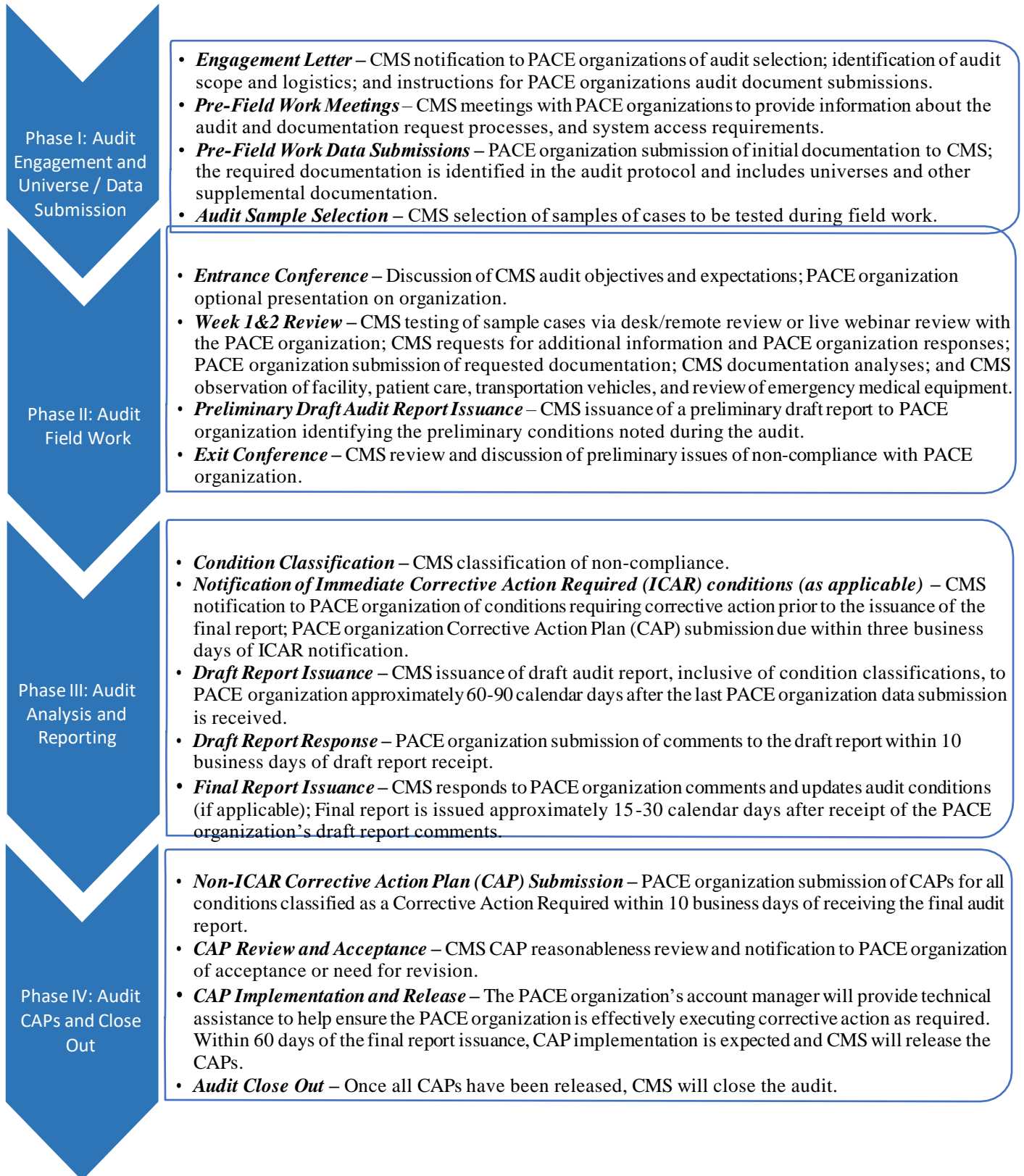
**Appendix A - Programs of All-Inclusive Care for the Elderly (PACE)
Audit Overview**

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

Executive Summary – PACE Audit Phase Timeline



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.

Summary of Audit Phases

The PACE audit consists of four phases:

- Audit Engagement and Universe/Data Submission
- Audit Field Work
- Audit Analysis and Reporting
- 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 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.

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.

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.