MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 22 (4/1/2020-3/31/2021)
Federal Fiscal Quarter: 4 (7/1/2020-9/30/2020)

I. Introduction

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) for its Partnership Plan Medicaid Section 1115 Demonstration. In implementing the Partnership Plan Demonstration, it was the State's goal to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan Demonstration was originally authorized for a five-year period and has been extended several times. CMS had approved an extension of the 1115 waiver on September 29, 2006 for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2016.

There have been several amendments to the Partnership Plan Demonstration since its initial approval in 1997. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team (MRT). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. Populations in the F-SHRP were transitioned into the 1115 Partnership Plan Waiver. A final draft evaluation report was submitted to CMS on February 11, 2015 and was approved by CMS on May 24, 2016.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30-day public comment period. A temporary extension was granted on December 31, 2014 which extended the waiver through March 31, 2015. Subsequent temporary extensions were granted through December 7, 2016. New York's 1115 Demonstration was renewed by CMS on December 7, 2016 through March 31, 2021. At the time of renewal, the Partnership Plan was renamed New York Medicaid Redesign Team (MRT) Waiver. On April 19, 2019 CMS approved New York's request to exempt MMMC

enrollees from cost sharing by waiving comparability requirements to align with the New York's social services law, except for applicable pharmacy co-payments described in the STCs. On August 2, 2019 CMS approved New York's request to create a streamlined children's model of care for children and youth under 21 years of age with behavioral health (BH) and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities. On December 19, 2019 CMS approved New York's request to limit the nursing home benefit in the partially capitated Managed Long Term Care (MLTC) plans to three months for enrollees who have been designated as "long-term nursing home stays" (LTNHS) in a skilled nursing or residential health care facility. The amendment also implements a lock-in policy that allows enrollees of partially capitated MLTC plans to transfer to another partially capitated MLTC plan without cause during the first 90 days of a 12-month period and with good cause during the remainder of the 12-month period.

New York is well positioned to lead the nation in Medicaid reform. Governor Cuomo´s Medicaid Redesign Team (MRT) has developed a multi-year action plan (A Plan to Transform the Empire State´s Medicaid Program) that when fully implemented will not only improve health outcomes for more than five million New Yorkers but also bend the state´s Medicaid cost curve. Significant federal savings have already been realized through New York´s MRT process and substantial savings will also accrue as part of the 1115 waiver.

II. Enrollment: Fourth Quarter

MRT Waiver- Enrollment as of September 2020

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	**490,038**	**4,054**	**11,142**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**90,857**	**1,269**	**2,083**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**13,036**	**158**	**160**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**2,616**	**51**	**41**
Population 5 - Safety Net Adults	**319,716**	**6,385**	**7,498**

Population 6 - Family Health Plus Adults with Children	**0**	**0**	**0**
Population 7 - Family Health Plus Adults without Children	**0**	**0**	**0**
Population 8 - Disabled Adults and Children 0 - 64 (SSI 0-64 Current MC)	**20,487**	**387**	**54**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**184,111**	**4,239**	**700**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,444**	**44**	**8**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**51,401**	**1,566**	**271**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**18,153 or an approximate 12.6% decrease from last Q**

Reasons for voluntary disenrollment: Enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

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

The quarter's significant decline in voluntary disenrollment is largely due to the decline in the disenrollment of the incarcerated and dually eligible.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	21,957 or an approximate 24.0% decrease from last Q

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

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

Involuntary disenrollment declined due to significant decreases in both ordinary case closures and MAGI case closures that were subsequently sent to NYSoH for redetermination.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
July 2020				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	846,167	23,322	5,310	18,012
Rest of State	290,119	15,499	1,171	14,328
Statewide	1,136,286	38,821	6,481	32,340
August 2020				
New York City	854,695	21,837	4,986	16,851
Rest of State	291,931	5,932	774	5,158
Statewide	1,146,626	27,769	5,760	22,009
September 2020				
New York City	866,615	22,223	6,800	15,423
Rest of State	294,145	6,498	1,058	5,440
Statewide	1,160,760	28,721	7,858	20,863

Fourth Quarter	
Region	**Total Affirmative Choices**
New York City	**50,286**
Rest of State	**24,926**
Statewide	**75,212**

HIV SNP Plans				
July 2020				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**12,901**	**116**	**0**	**116**
Rest of State	**10**	**3**	**0**	**3**
Statewide	**12,911**	**119**	**0**	**119**
August 2020				
New York City	**12,933**	**85**	**0**	**85**
Rest of State	**9**	**0**	**0**	**0**
Statewide	**12,942**	**85**	**0**	**85**
September 2020				
New York City	**12,938**	**106**	**0**	**106**
Rest of State	**8**	**0**	**0**	**0**
Statewide	**12,946**	**106**	**0**	**106**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**307**			
Rest of State	**3**			
Statewide	**310**			

Health and Recovery Plans Disenrollment			
FFY 20 – Q4			
	Voluntary	Involuntary	Total
July 2020	441	325	766
August 2020	483	365	848
September 2020	676	316	992
Total:	1,600	1,006	2,606

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 4 (7/1/2020-9/30/2020) Q4 FFY 2020

As of the end of the fourth federal fiscal quarter (end of September 2020), there were 2,709,161 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Program and 71,617 Medicaid consumers enrolled in Health and Recovery Plan (HARP). MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 15 HRA facilities open to the public and has suspended outreach activities at 18 HRA facilities temporarily closed due to COVID-19. MAXIMUS reported that 8,199 clients were educated about enrollment options and made an enrollment choice including 290 clients in person and 7,909 clients through phone.

Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Deficiency found is reported to MAXIMUS Field operation monthly. Due to COVID-19, CMU field monitoring has been suspended since 3/23/2020; therefore, no activity was conducted for the reporting period.

B. Auto-Assignment (AA) Outreach Calls for Fee-For-Service (FFS) Consumers

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 28,041 FFS community clients were reported on the regular auto-assignment list, 4,217 clients responded to the call that generated 4,689 enrollments. Of the total of 130 FFS NH clients

reported on NH auto-assignment list, 38 (29%) clients and/or authorized representatives made a plan selection.

C. NYMC HelpLine Observations July 2020-September 2020

NYMC reported that 68,570 calls were received by the Helpline and 57,834, or 84%, were answered. Calls answered were handled in the following languages: English: 39,036 (67%); Spanish: 7,651 (13%); Chinese: 2,583 (4%); Russian: 560 (2%); Creole: 100 (1%) and other: 7,904 (13%).

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. Call observation was also suspended, and no activity was recorded for the reporting period.

Annual Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations: FFY 2020 (10/1/2019-9/30/2020)

As of the end of the federal fiscal year 2020 (end of September 2020), there were 2,709,161 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Program and 71,617 Medicaid consumers enrolled in Health and Recovery Plan (HARP). MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the first two quarters of FFY 2020, MAXIMUS Field Customer Service Representatives (FCSRs) conducted outreach in 33 HRA facilities including 6 HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 17,371 clients were educated about their enrollment options and 10,772 (62%) clients made an enrollment choice.

Due to COVID-19, outreach activities at 18 of the 33 HRA facilities has been temporarily closed. MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 15 HRA facilities opened to the public. MAXIMUS reported that 10,359 clients were educated about enrollment options and made an enrollment choice including 470 clients in person and 9,889 clients through phone.

Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Deficiency found is reported to MAXIMUS Field operation monthly. During the first six (6) months, 792 Enrollment Counselling sessions were evaluated which generated applications for a total of 976 enrollments. CMU field monitoring has been suspended since 3/23/2020; therefore, no activity was conducted for the third and fourth quarter.

CMU Monitoring of Field Presentation Report – 10/1/2019 – 3/31/2020	
Enrollment Counseling - One on One	**General Information**
792	2,622

Infractions were observed for 146 (18%) of the 792 Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA.

Key messages most often omitted regarding Enrollment Counselling were failure to disclose or explain the following:

- Use of plan ID Card/Benefit Card
- Good Cause Transfer
- Exemptions
- Confirmation Letter
- Emergency/Urgent Care

Of the 976 enrollments completed during informational sessions, 944 (97%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

B. Auto-Assignment (AA) Outreach Calls for Fee-For-Service (FFS) Consumers

Phone Enrollment			General Information (undecided)		
Regular FFS	**Nursing Home FFS**	**Total**	**Regular FFS**	**Nursing Home FFS**	**Total**
373	4	377	446	5	451

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 95,411 FFS community clients was reported on the regular auto-assignment list, 14,007 (15%) clients responded to the call and generated 14,009 enrollments. Of the total of 442 FFS NH clients reported on NH auto-assignment list, 86 (19%) clients and/or authorized representatives made a plan selection. CMU monitored 828 outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 377 (46%) FFS clients made a voluntary enrollment choice for themselves and their family members including 4 NH clients for a total of 401 enrollments.
    - 485 (75%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 451 (54%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 163 (44%) of the 369 regular FFS AA Phone Enrollment conducted by NYMC FCSRs at HRA sites and none were observed for the 4 NH outreach calls. Key messages most often omitted were failure to disclose or explain the following:

- Urgent Care
- Choice of Plans
- Use of plan ID Card/Benefit Card
- Good Cause Transfer

CMU also randomly selected 410 (1%) clients from the auto-assignment list of 37,870 clients to see if outreach calls were conducted, the plan selected by the consumer was indicated, and notices were sent in a timely manner. It was reported that 147 (36%) consumers were reached and 121 (82%) of the 147 that responded made a plan choice. CMU also confirmed that appropriate and timely notices were sent to the 289 clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

NYMC is required to develop, implement and submit a corrective action plan for each infraction identified and a total of 163 corrective action plans were implemented for the reporting period. Corrective actions include, but are not limited to, staff training and an increase in targeted FCSR monitoring to ensure compliance.

C. NYMC HelpLine Observations October 2019-March 31, 2020

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 220,682 calls were received by the Helpline and 194,806 or 88% were answered. Calls answered were handled in the following languages: English: 126,052 (65%); Spanish: 23,647 (12%); Chinese: 6,902 (3%); Russian: 1,917 (1%); Haitian/Creole: 227 (1%); and other: 36,061 (18%).

MAXIMUS recorded 100% of the calls received by the NYMC Helpline 10/1/2019 through 3/20/2020 and suspended recording of calls since CSRs answered calls from home due to COVID-19. Call monitoring was therefore suspended.

CMU listened to 4,459 recorded calls for the report period. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 10/1/2019 - 3/31/2020						
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Removal of Restriction**	**Total**
3,335 (75%)	164 (4%)	279 (6%)	628 (14%)	53 (1%)	0 (0%)	4,459

A total of 2,006 (45%) recorded calls observed were unsatisfactory including 1,148 calls with single infraction and 858 calls with multiple infractions, A total of 1,954 infractions/issues were reported to MAXIMUS. The following summarizes those observations:

- Process: 2,200 (96%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 30 (1%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 69 (3%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 2,299 corrective action plans were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

Below is a listing of the transactions completed by BMCCS 7/1/2020 – 9/30/2020:

- HealthFirst PHSP, Inc. expanded into Rockland County for Medicaid Managed Care, Health and Recovery Plan, and Child Health Plus.
- On July 1, 2020, Molina Healthcare of New York, Inc. was approved to expand its Medicaid Managed Care (MMC) and Health and Recovery Plan (HARP) service areas to include Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne and Wyoming counties; and
- On July 1, 2020, YourCare Health Plan, Inc. (YourCare) was approved to withdraw its MMC and HARP products from Allegany, Cattaraugus, Chautauqua, Erie, Monroe, Ontario and Wyoming counties. This withdrawal was the result of the acquisition of YourCare by Molina Healthcare of New York, Inc.

Annual Plan Expansions, Withdrawals, and New Plans

There were three approved plan expansions that occurred during the fiscal year:

- On October 9, 2019, VNS Choice was approved to expand its HIV Special Needs Plan Service Area to include Nassau and Westchester counties.
- On November 19, 2019 Molina HealthCare of New York was approved to expand it Medicaid Managed Care and Health and Recovery Plan service area to include Broome, Chenango and Tioga counties.
- On July 1, 2020 Molina HealthCare of New York was approved to expand it Medicaid Managed Care, Health and Recovery Plan Child Health Plus and Essential Plan service

area to include Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne and Wyoming counties.

On December 31, 2019, New York Quality Health Care Corporation's asset purchase of WellCare of New York, Inc. closed. Members migrated June 1, 2020.

On June 1, 2020, Wellcare of New York, Inc. withdrew its MMC product line from Albany, Bronx, Broome, Dutchess, Erie, Kings, Nassau, New York, Niagara, Orange, Queens, Rensselaer, Richmond, Rockland, Schenectady, Schuyler, Steuben, Suffolk and Ulster counties.

On June 30, 2020, Molina HealthCare of New York Inc.'s asset purchase of YourCare Health Plan, Inc. closed. Members migrated July 1, 2020.

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

The March 1, 2019 Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract) was submitted to CMS for approval in federal fiscal year (FFY) 2018-2019. During FFY 2019-2020, the following actions related to the review and execution of the Model Contract transpired:

- On August 29, 2019, New York State (NYS) received comments from CMS regarding their review of the Model Contract which necessitated some contract language modifications to remedy;
- On November 21, 2019, NYS submitted Model Contract language changes to CMS that addressed CMS review comments;
- On May 28, 2020, New York commenced sending out the individual contracts to the Managed Care Organizations (MCOs) for signature;
- At the close of FFY 2019-2020, 9 of the 19 MCO contracts had been sent to CMS for approval. The remaining 10 MCO contracts were in various stages of the NYS approval process.

C. Health Plans/Changes to Certificates of Authority

None to report.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

CMS MRT QTR 4 and End of Year Surveillance Report FFY 2019-2020

Due to COVID-19 a CMS 1135 Waiver was granted to pause surveillance activity.

Q4

Surveillance Activities

Surveillance activity completed during the 4th Quarter FFY 2019-2020 (July 1, 2020 - September 30, 2020) include the following:

Two (2) Comprehensive Operational Surveys were completed during 4th Quarter FFY 2019-2020. Two (2) SODs were issued and Two (2) POCs were accepted.

- Molina
- VNSNY Choice

Yearly Report

Surveillance Activities

Surveillance activity completed during the FFY 2019-2020 (October 1, 2019 – September 30, 2020) include the following:

Seven (7) Comprehensive Operational Surveys was completed during FFY 2019-2020. Seven (7) SODs were issued and Seven (7) POCs were accepted.

- VNSNY Choice
- Molina
- UnitedHealthcare
- HealthNow New York, Inc.
- WellCare
- Healthfirst
- EmblemHealth (HIP)

Five (5) Targeted Operational Surveys was completed during FFY 2019 2020. Four (4) SOD issued and Four (4) POC was accepted. One (1) Plan was found in compliance.

- Healthplus (Amerigroup)
- Excellus
- NYQHP dba Fidelis Care (In compliance)
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. (SNP)

Member Services Focus Survey Results were issued to 18 (eighteen) Plans. No SODs were issued. Letters of concern were sent to 17 (seventeen) Plans, and one Plan was found in Compliance:

- Affinity Health Plan
- Amida Care
- CDPHP
- EmblemHealth (HIP)
- Excellus
- NYQHP dba Fidelis Care
- Healthfirst
- HealthNow New York, Inc.

- Healthplus (Amerigroup)
- Independent Health Association (In compliance)
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. (SNP)
- Molina Healthcare of New York
- MVP Health Care
- UnitedHealthcare
- VNSNY CHOICE
- WellCare
- Yourcare Health Plan

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during FY2020. Final reports were previously submitted for all reviews except for the one involved in an open legal matter.

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

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance
  The final summary report was forwarded to the regional CMS office and CMS Central Office on July 1, 2015.

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

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

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

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

B. Benefit Changes/Other Program Changes

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

In October 2015 New York State began transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health (mental health and substance use disorder) and physical health service system that provides comprehensive, accessible, and recovery-oriented services. There are three components of the transition: expansion of covered behavioral health services in Medicaid Managed Care, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of Health and Recovery Plans (HARPs). HARPs are specialized plans that include staff with enhanced behavioral health expertise. In addition, individuals who are enrolled in a HARP can be assessed to access additional specialty services called behavioral health Home and Community Based Services (BH HCBS). For Medicaid Managed Care (MMC), all Medicaid- funded behavioral health services for adults, except for services in Community Residences, are part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

As part of the transition, the New York State Department of Health (DOH) began phasing in enrollment of current MMC enrollees throughout New York State into HARPs beginning with adults 21 and over in New York City in October 2015. This transition expanded to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) now provide all covered services available through Medicaid Managed Care.

In Fiscal Year (FY) 2018, New York State engaged in multiple activities to enhance access to behavioral health services and improve quality of care for recipients in Medicaid Managed Care. In June of 2018, HARP became an option on the New York State of Health (Exchange). This enabled 21,000 additional individuals to gain access to the enhanced benefits offered in the HARP product line. The State identified and implemented a policy to allow State Designated Entities to assess and link HARP enrollees to BH HCBS, and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult BH HCBS. Additionally, the State continually offers ongoing technical assistance to the behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center.

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

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

NOTE: As previously messaged to CMS in the 3rd quarter report, these reports were delayed allowing Plans the ability to shift resources and implement all COVID-19 guidance issued by the State. The State resumed reporting in September 2020. At this time the State does not have data to report on inpatient denials as it is still analyzing data from the reports most recently collected on October 1, 2020 which includes reporting months February 2020 through August 2020. As a result, the State will provide updated information with the next quarterly submission to CMS and will include a report for the previous two quarters as well as an annual report.

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

   NOTE: As previously messaged to CMS in the 3rd quarter report, these reports were delayed allowing Plans the ability to shift resources and implement all COVID-19 guidance issued by the State. The State resumed reporting in September 2020. At this time the State does not have data to report on outpatient denials as it is still analyzing the reports most recently collected on October 1, 2020 for April 2020 and July 2020 reports. As a result, the State will provide updated information with the next quarterly submission to CMS and will include a report for the previous two quarters as well as an annual report.

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

Mental Health (MH) & Substance Use Disorder (SUD) Claims (7/1/2020-9/30/2020)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	**1,092,286**	**91.94%**	**8.06%**
Rest of State	**945,331**	**93.34%**	**6.66%**
Statewide Total	**2,037,617**	**92.59%**	**7.41%**

BH Adults HCBS Claims/Encounters 7/1/2020-9/30/2020: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	67	26
Education Support Services	502	144
Family Support and Trainings	21	3
Intensive Crisis Respite	0	0
Intensive Supported Employment	318	85
Ongoing Supported Employment	31	9
Peer Support	1,892	431
Pre-vocational	204	47
Provider Travel Supplements	31	15
Psychosocial Rehab	384	58
Residential Supports Services	93	17
Short-term Crisis Respite	226	39
Transitional Employment	13	3
TOTAL	3,782	765

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

BH Adults HCBS Claims/Encounters 7/1/2020-9/30/2020: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	771	153
Education Support Services	862	273
Family Support and Trainings	46	16
Intensive Crisis Respite	0	0
Intensive Supported Employment	536	134
Ongoing Supported Employment	107	19
Peer Support	4,189	1,025
Pre-vocational	304	84
Provider Travel Supplements	1,868	533
Psychosocial Rehab	2,104	448
Residential Supports Services	2,089	400
Short-term Crisis Respite	146	37
Transitional Employment	0	0
TOTAL	13,022	2,204

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

4. Annual Mental Health (MH) & Substance Use Disorder (SUD) Claims (10/1/2019-9/30/2020)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	4,734,198	87.95%	12.05%
Rest of State	3,691,892	91.45%	8.55%
Statewide Total	8,462,090	89.48%	10.52%

BH Adults HCBS Claims/Encounters 10/1/2019-9/30/2020: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	532	68
Education Support Services	2,410	360
Family Support and Trainings	74	8
Intensive Crisis Respite	0	0
Intensive Supported Employment	1,447	230
Ongoing Supported Employment	153	21
Peer Support	12,512	1,100
Pre-vocational	1,197	175
Provider Travel Supplements	1,229	367
Psychosocial Rehab	2,678	184
Residential Supports Services	904	88
Short-term Crisis Respite	1,664	195
Transitional Employment	175	19
TOTAL	24,975	1,997

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

BH Adults HCBS Claims/Encounters 10/1/2019-9/30/2020: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	5,705	450
Education Support Services	6,686	813
Family Support and Trainings	292	38
Intensive Crisis Respite	0	0
Intensive Supported Employment	3,180	368
Ongoing Supported Employment	592	53
Peer Support	25,503	2,102
Pre-vocational	2,091	246
Provider Travel Supplements	15,660	2,061
Psychosocial Rehab	12,455	830
Residential Supports Services	9,903	720
Short-term Crisis Respite	748	129
Transitional Employment	52	14
TOTAL	82,867	4,449

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

Provider Technical Assistance

Managed Care Technical Assistance Center is a partnership between the McSilver Institute for Poverty Policy and Research at New York University School of Social Work and the National Center on Addiction and Substance Abuse (CASA) at Columbia University, as well as other community and State partners. It provides tools and trainings that assist providers to improve business and clinical practices as they transition to managed care. See below for Managed Care Technical Assistance Stats during July 1, 2020 to September 30, 2020.

Last Quarter (July – September 2020)
MCTAC Attendance & Stats
Time Period: 7/1/2020 to 9/30/2020

Events: MCTAC successfully executed 17 events from 7/1/2020 to 9/30/2020. All 17 events were held via webinar.

Individual Participation: 1445 people attended/participated in our events of which 1024 are unique.

***There were an additional 144 attendees who were unregistered in MCTAC system, of which 117 were unique participants.*

OMH Agency Participation
Overall: 346 of 635 **(54.49%)**
NYC: 203 of 331 **(61.33%)**
ROS: 161 of 434 **(37.10%)**

OASAS Agency Participation
Overall: 129 of 547 **(23.58%)**
NYC: 44 of 240 **(18.33%)**
ROS: 145 of 379 **(38.26%)**

Last Year (October 1, 2019– September 30, 2020)
MCTAC Attendance & Stats
Time Period: 10/1/2019 to 9/30/2020

Events: MCTAC successfully executed 69 events from 10/1/2019 to 9/30/2020. 24 events were held in person and 45 were held via webinar.

Individual Participation: 5139 people attended/participated in our events of which 2883 are unique participants.

***There were an additional 1411 attendees who were unregistered in MCTAC system, of which 1129 were unique participants.*

OMH Agency Participation
Overall: 474 of 635 **(74.65%)**
NYC: 259 of 331 **(78.25%)**
ROS: 336 of 434 **(77.42%)**

OASAS Agency Participation
Overall: 241 of 547 **(44.06%)**
NYC: 79 of 240 **(32.92%)**
ROS: 168 of 379 **(44.33%)**

Efforts to Improve Access to Behavioral Health Home and Community Based Services (BH HCBS)

All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) have been made available to eligible HARP and HIV SNP enrollees. These services are designed to provide enrollees with specialized supports to remain in the community and assist with rehabilitation and recovery. Enrollees must undergo an assessment to determine BH HCBS eligibility. Effective January 2016 in NYC and October 2016 for the rest of the state, BH HCBS were made available to eligible individuals.

As discussed with CMS, New York experienced slower than anticipated access to BH HCBS for HARP members and has actively sought to determine the root cause for this delay. Following

implementation of BH HCBS, the State and key stakeholders identified challenges, including: difficulty with enrolling HARP members in Health Homes (HH); locating enrollees and keeping them engaged throughout the lengthy assessment and Plan of Care development process; ensuring care managers have understanding of BH HCBS (including person-centered care planning) and capacity for care managers to effectively link members to rehab services; and difficulty launching BH HCBS due to low number of referrals to BH HCBS providers.

NYS is continuing its efforts to ramp up utilization and improve access to BH HCBS by addressing the challenges identified. These efforts include:

- Streamlining the BH HCBS assessment process
    - Effective March 7, 2017, the full portion of the New York State Community Mental Health assessment is no longer required. Only the brief portion (NYS Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Developed training for care managers and BH HCBS providers to enhance the quality and utilization of integrated, person-centered plans of care and service provision, including developing a Health Home training guide for key core competency trainings to serving the high need SMI population.
- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both HH and RCAs).
- Developed required training for BH HCBS providers that the State can track in a Learning Management System.
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training.
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in HH. These services are provided by State Designated Entities (SDE) through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with State-designated entities to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCA) for the provision of assessments and development of plans of care for BH HCBS.
    - Additional efforts to support initial implementation of RCAs include:
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs
        - Ongoing technical assistance
        - Creation of statewide RCA performance dashboard- enhanced to reflect data by RCA and by HH

- Continuing efforts to increase HARP enrollment in HH including:
    - Best practices for embedded care managers in ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies
    - Existing quality improvement initiative within clinics to encourage HH enrollment
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings
    - PSYCKES quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management
    - DOH approval of MCO plans for incentivizing enrollment into HH (eg, Outreach Optimization)

- Ongoing work to strengthen the capacity of HH to serve high need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
    - Provided technical assistance to lead HHs, representation on new HH+ Subcommittee Workgroup.
- Implementing Performance Management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets for and key quality metrics for access to BH HCBS for HARP members.
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS Office of Mental Health has contracted with NYAPRS to conduct peer-focused outreach and training to possible eligible members for Medicaid Managed Care Health and Recovery Plans (HARPs) and Adult Behavioral Health (BH) Home and Community Based Services (BH HCBS).
        - NYAPRS conducts outreach in two ways:
            - Through 45-90-minute training presentations delivered by peers.
                - OMH approves the PowerPoint before significant changes are made.
            - Through direct one-to-one outreach in community spaces (such as in homeless shelters or on the street near community centers).
- Implemented Quality and Infrastructure initiative to support targeted BH HCBS workflow processes and increase in BH HCBS utilization. In-person trainings completed June 2018. The State works with the Managed Care Plans on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS. Infrastructure contracts have been signed and work is underway.
    - $43.4 million is contracted through 13 HARPs to 98 providers.
    - Outreach to all MCOs was conducted to discuss best practices identified through the use of Quality and Infrastructure initiative funds that resulted in increased # of members utilizing BH HCBS; a summary of best and promising practices will be shared with MCOs.

- Updates being made to Non-Medical Transportation guidance to improve utilization of this service intended to support participation in BH HCBS and attainment of recovery goals.
- Issued Terms and Conditions for BH HCBS Providers to standardize compliance and quality expectations of BH HCBS provider network and help clarify for MCOs which BH HCBS Providers are actively providing services.
- Enhancing State Adult BH HCBS Provider oversight including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.
- Continued work with the HARP/ BH HCBS Subcommittee (since 2017) – consisting of representatives from MCOs, HHs, CMAs, and BH HCBS Provider agencies - charged with identifying barriers and solutions for improved access to BH HCBS, on behalf of NYS' HH/MCO Workgroup.
- A process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments was established, in response to challenges in securing a CM workforce meeting both the education and experience criteria and need for more assessors.

Despite extensive efforts outlined above and stakeholder participation to implement strategies for improved utilization of BH HCBS, the number of HARP enrollees successfully engaged with BH HCBS overall remain very low. NYS reviewed a significant amount of feedback from MCOs, Health Homes, Care Managers and other key stakeholders and determined the requirements for accessing HCBS were too difficult to standardize among 15 MCOs and 30 Health Homes. In June 2020, NYS released a draft proposal for public comment for transitioning 1115 Waiver BH HCBS into a State Adult Rehabilitation Services package for HARP enrollees, which to date has resulted in very positive feedback. The State finalized the proposal and submitted to CMS September 2020. The objectives of this transition are two-fold: to simplify and allow creativity in service delivery of community-based rehabilitation services tailored to the specific needs of the behavioral health population, and to eliminate barriers to access. If approved by CMS, access to these rehabilitation services will be by recommendation of a licensed practitioner of the healing arts (LPHA). Enrollment in Health Home Care Management will continue to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care the Health Home offers. Care managers will always have the important role of ensuring timely access to services reflective of the member's preferences and individual needs, in continued collaboration with the MCO and service providers.

To date, 4,682 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between July 1, 2020 and September 30, 2020 6,381 eligibility assessments were completed. The total number of eligibility assessments completed for the time period 10/1/2019-9/30/2020 is 28,644.

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

The Gap Report Pilot focus group remains on hold, due to the COVID-19 pandemic. However, the Department plans to begin the monthly Gap Report focus group calls in October 2020. A copy of the gap report template, instructions, and additional information about the transition can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_8401.htm.

Annual: In the Fall of 2019, the Department agreed to work with a focus group (SBHCs & MMCPs) to pilot the use of the Department issued gap report template. The first meeting to roll-out the details of the SBHC/MMCP Gap Pilot was held on January 7, 2020, ten SBHCs, and four MMCPs agreed to participate in the Pilot. At the January 7, 2020 meeting, the Department committed to supporting MMCPs and SBHCs participating in the Gap Report Pilot, by scheduling periodic calls for participants to review questions or concerns that arise during the data exchange process. The Department held two calls, one in February 2020 and one in March 2020, to monitor the progress of the data exchange between the MMCPs and the SBHCs. In late March 2020, the Gap Report Pilot focus group was placed on hold, due to the COVID-19 pandemic. The Department recognized the challenges produced by the COVID-19 pandemic and continued to ensure that we would not implement the transition at a time when stakeholders were largely not prepared to move forward with the transition. However, the Department encouraged Plans to continue to obtain contracts with SBHCs in preparation for the upcoming 2021 implementation.

C. Managed Long-Term Care Program (MLTCP)

Managed Long-Term Care (MLTC) plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), Medicaid Advantage (MA), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA IDD). As of October 1, 2020, there are 25 Partial Capitation plans, 9 PACE plans, 10 MAP, 3 MA plans, and 1 FIDA IDD plan. As of October 1, 2020, there is a total of 272,176 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the July 2020 through September 2020 quarter, 2 MAP plans expanded service area operations.

During the annual period of October 2019 through September 2020, the Department of Health (Department) approved service area expansions for 2 Partial Capitation plans, 1 PACE plan, and 2 MAP plans. During that same annual period, the Department approved the opening of 2 new MAP plans, and the closing of 1 Partial Capitation plan.

New York's Enrollment Broker, New York Medicaid Choice (NYMC), conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were

receiving prior to mandatory transitions to MLTC. For the July 2020 through September 2020 quarter, post enrollment surveys were completed for 13 enrollees. 11 of the 13 enrollees (85%) who responded indicated that they continued to receive services from the same caregivers once they became members of an MLTC plan. The percentage of affirmative responses remains consistent with previous quarters.

Enrollment: Total enrollment in MLTC Partial Capitation plans fell from 286,193 to 272,176 during the July 2020 through September 2020 quarter, a 5% decrease over the last quarter. For that period, 11,788 individuals who were being transitioned into Managed Long-Term Care made an affirmative choice, a 19% increase from the previous quarter. This brings the 12-month total for affirmative choice to 48,752. Monthly plan-specific enrollment for Partial Capitation plans during the October 2019 through September 2020 annual period is submitted as an attachment.

Total enrollment for MLTC PACE remains consistent at 5,559. Total enrollment for MLTC MAP grew from 21,391 to 22,369 during the July 2020 through September 2020 quarter, a 5% increase over the previous quarter. Monthly enrollment for MAP and PACE plans during the October 2019 through September 2020 annual period is submitted as an attachment.

2. Significant Program Developments

During the July 2020 through September 2020 quarter:

- The 3rd Quarter Member Services survey was conducted on 25 Partial Capitation Plans and 8 MAP Plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required, but when necessary the Department provided recommendations on areas of improvement. The results were sent to the plans in October 2020;

- 1 Operational Survey has been completed for a Partial Capitation Plan and 1 Operational Survey has been completed for a MAP Plan;

- 6 Operational Surveys are ongoing on Partial Capitation;

- Of the 15 Statements of Deficiencies (SOD) issued to 1 plan in State Quarter 1, based on complaints received by the Technical Assistance Center (TAC), 3 Corrective Action Plans are still in progress; and

- The contract for the NYS MLTC Ombudsman has been finalized. The Community Service Society of New York has been selected.

As a matter of routine course:

- Processes for Operational Partial Capitation and MAP surveys continue to be refined;
- The Surveillance tools continue to be updated to reflect process changes; and
- Reports have been developed/implemented to assist with summarizing survey findings.

In addition to the fourth quarter activities discussed above, below is a summary of other activities that have occurred during the October 2019 through September 2020 annual period:

- The Second round of Partial Capitation Operational and Focused Surveys have been initiated. As of September 30, 2020, 5 Operational Surveys have been completed and 6 Operational Surveys are in various stages of the survey process.
- The First round of MAP Operational Surveys have been initiated. As of September 30, 2020, 1 Operational survey has been completed.
- 35 Complaint Investigation Surveys were completed. These surveys assessed the plan's compliance with its Medicaid contract based on complaints received in the TAC unit. 19 SODs were issued to 1 plan, 15 SODs were issued to another plan, and 1 SOD was issued to a third plan.
- Quarterly Member Services Surveys are conducted on all Partial Capitation and MAP Plans. Quarterly reports are issued to each plan to assist them in improving the overall functioning of their member service department. No response is required, but when necessary the Department provides recommendations on areas of improvement. Note: The Member Services Surveys were not conducted in the 2nd quarter of 2020 due to the pandemic.
- The Partial Capitation and MAP Operational Surveys were suspended from March 2020 through August 2020 due to the COVID-19 Pandemic. Routine Operational Surveys have resumed since September 2020.
- The Surveillance tools are continually updated to reflect process changes.

3. Issues and Problems

There were no significant issues or problems to report for the July 2020 through September 2020 quarter, nor for the October 2019 through September 2020 annual period.

4. Summary of Self-Directed Options

Self-direction is provided under Consumer Directed Personal Assistance Program (CDPAP) within the MLTC plan as a consumer choice and gives individuals and families greater control over services received. Plans continue to be required to contract with a minimum of 2 Fiscal Intermediaries in each county. The requirement continues to be monitored on a quarterly basis, and all plans are meeting that requirement.

5. Required Quarterly Reporting

Critical incidents: There were 1,680 critical incidents reported for the July 2020 through September 2020 quarter, an increase of 24% over the last quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey. To date, none of those plans were found to have had critical incidents that should have been reported. For the annual period October 2019 through September 2020, critical incidents increased by 8% from the previous annual period. Critical incidents by plan for this quarter are attached.

Complaints* and Appeals: For the July 2020 through September 2020 quarter, the top reasons for complaints/appeals: Denial of Expedited Appeal, Violation of Other Enrollee Rights, Waiting Time Too Long in Provider's Office, Hearing/Vision Needs Not Accommodated, Language Translation Services Not Available. This data includes the MLTC enrollees for Partial Capitation, PACE, and MAP enrollees.

Period: 7/1/2020 through 9/30/2020 **(Percentages rounded to nearest whole number)**			
Number of Recipients Partial, PACE, MAP: 270,489	**Complaints**	**Resolved**	**Percent Resolved****
Expedited	**10**	**8**	**80%**
# Same Day	**4,653**	**4,653**	**100%**
# Standard	**8,833**	**8,062**	**91%**
Total for this period:	**13,496**	**12,723**	**94%**

*The term "complaint" is replacing the previously used term "grievance" that was previously used in order to match contract language. The definition of the terms is interchangeable.

**Percent Resolved includes grievances opened during previous quarters that are resolved during the current quarter, that may result in creating a percentage greater than 100.

Appeals (Partial, MAP, PACE)	10/2019-12/2019	1/2020-3/2020	4/2020-6/2020	7/2020-9/2020	Average for Four Quarters
Average Enrollment	271,744	279,048	281,967	270,489	275,812
Total Appeals	8,889	9,655	5,804	8,044	8,098
Appeals per 1,000	33	35	21	30	30
# Decided in favor of Enrollee	1,612	1,854	917	876	1,315
# Decided against Enrollee	5,751	6,713	5,373	5,121	5,740
# Not decided fully in favor of Enrollee	464	727	523	452	542
# Withdrawn by Enrollee	206	200	199	169	194
# Still pending	1,549	1,752	528	1,050	1,220
Average number of days from receipt to decision	9	9	9	15	11

*Complaints and Appeals per 1,000 Enrollees by Product Type July-September 2020					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	242,898	7,949	33	5,589	23
Medicaid Advantage Plus (MAP) Total	22,021	4,490	204	1,267	57
PACE Total	5,570	1,057	190	65	11
Total for All Products:	**270,489**	**13,496**	**50**	**6,921**	**26**

Total complaints decreased 17% from 16,334 the previous quarter to 13,496 during the July 2020 through September 2020 quarter. The total number of appeals increased 39% from 5,804 during the last quarter to 8,044 during the July 2020 through September 2020 quarter.

For the annual period October 2019 through September 2020, the number of complaints grew by 16%, and the number of appeals grew by 58%.

Technical Assistance Center (TAC) Activity

During the July 2020 through September 2020 quarter, TAC opened slightly less cases than in the 3rd quarter. However, the call volume and case generation were within typical range for the unit.

There was an increase in complaints surrounding enrollee dissatisfaction with their Inter-Disciplinary Team (IDT) during the fourth quarter. This is mostly due to COVID-19-related

care management and service coordination by the plans. Many members were concerned about how their services would be provided during lockdown and quarantine.

Call Volume	**7/1/2020- 9/30/2020**	**10/1/2019-9/30/2020**
Substantiated Complaints	99	444
Unsubstantiated Complaints	264	1,193
Complaints Resolved Without Investigation	39	111
Inquiries	191	987
Total Calls	**593**	**2,735**

The five most common types of calls were related to:

4th Quarter			Annually	
Call Type	**7/1/2020- 9/30/2020**		**Call Type**	**10/1/2019 - 9/30/2020**
1. Aide Service	20%		1. Aide Service	20%
2. General	14%		2. General	16%
3. Billing	13%		3. Enrollment	15%
4. IDT	9%		4. Billing	13%
5. Grievance- Noncompliance	9%		5. Grievance	12%

TAC continues to take the most cases for complaints against aide service. However, compared to last year, the most frequent categories have changed. TAC has seen a decrease in billing and DME complaints. There has been an increase in general inquiries, enrollment complaints, and grievances. Much of this is due to Medicaid policy changes surrounding COVID-19.

During the annual period from October 2019 through September 2020, the TAC Unit took in a total of 2,557 cases and resolved 2,757 cases. Part of the discrepancy between these numbers is due to a database issue where we had to reopen many old cases. That issue has been fixed as of August.

62% of cases are closed in the same month they are opened. This is up 17% from last year. This is mostly due to improvements made to our workflow. We have also seen a 5% increase in efficiency since the March. This is most likely due to an increase of COVID-19-related inquiries and questions.

TAC's complaint numbers have remained consistent when compared to the previous year. Though we have seen an increase in COVID-19-related calls, we have also noticed a decrease in other types of complaints. Specifically, we have seen an increase in inquiries and a decrease in unsubstantiated cases.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the July 2020 through September 2020 quarter, 11,010 people were evaluated, deemed eligible and enrolled into plans, an increase of 33% from the previous quarter. This brings the total for the annual period October 2019 through September 2020 to 43,158.

Referrals and 30-day assessment: For the July 2020 through September 2020 quarter, MLTC plans conducted 24,848 assessments, a 22% increase from 20,431 the previous quarter. The total number of assessments conducted within 30 days increased 27% from 17,083 the previous quarter, to 21,683 this quarter. During the annual period October 2019 through September 2020, a total of 93,443 assessments were completed, with 83% of those assessments being conducted within 30 days of the request, which remains consistent with the previous annual period. The Department continues to monitor data collection, evaluation and reporting of CFEEC activity.

Referrals outside enrollment broker: For the July 2020 through September 2020 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 17,772, a slight increase from 17,709 the previous quarter. The annual period October 2019 through September 2020 saw a decrease totaling 33% by the end of the year, compared to the decrease from the previous annual period (12%).

Rebalancing Efforts	7/2020-9/2020
New Enrollees to the Plan from a nursing home transitioning to the community	128
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	4,933
New Enrollees permanently placed in a nursing home who remain in a nursing home	109

As of October 2020, there were 4,564 current plan enrollees who were in nursing homes as permanent placements, a 71% decrease from the last quarter. The decrease was due to the Long Term Nursing Home Stay (LTNHS) Partial Capitation benefit limitation.

D. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with behavioral health (BH) and Home and Community Based Service (HCBS) needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and

developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS.

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

- Managed care authority for HCBS provided to medically fragile children in foster care and/or with developmental disabilities and children with a serious emotional disturbance;
- Authority to include current Fee for Service HCBS authorized under the State's newly consolidated 1915c children's waiver in Medicaid Managed Care benefit packages;
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915c Children's waiver;
- Authority to waive deeming of income and resources, if applicable, for all medically needy "Family of One" children (Fo1 children) who will lose their Medicaid eligibility as a result of them no longer receiving at least one 1915c service due to case management now being covered outside of the 1915c children's waiver, including non-Supplemental Security Income Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs;
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115;
- Authority to provide customized goods and services, such as self- direction and financial management services, that are currently approved under the demonstration's HARP's pilot to Fo1 children;
- Authority for Health Home care management monthly monitoring as an HCBS; and
- Removes managed care exclusion of children placed with Voluntary Foster Care Agencies.

Given the recent approval, the New York State Department of Health has been engaged in implementation activities, including, but not limited to the following:

- Receiving approval from CMS for the Children's 1115 Evaluation Design as of April 16, 2020;
- Continuing to refine data collection and data analysis to ensure accurate reporting;
- Engaging a contract vendor for performance and quality monitoring for all elements of the Children's Redesign, including the Children's 1115 Waiver, to ensure consistency and quality in all elements of the initiative;
- Preparing data and deliverables to share with the vendor upon contract execution to ensure a timely submission of the Preliminary Interim Evaluation to CMS;
- Drafting policies and guidance to ensure compliance with State and federal requirements;
- Defining performance and quality metrics; and

- Responding to the COVID-19 pandemic and drafting emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers.

The above-listed activities will help to facilitate oversight and the provision of high-quality services, ensure that the goals of the Children's 1115 Waiver are achieved, and provide the necessary data elements to fulfill future reporting requirements.

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

	With K1 Flag - HCBS LOC		With KK Flag - Family of One	
Month	Enrolled Children	Enrolled Children w/ Claims	Enrolled Children	Enrolled Children w/ Claims
	Enrolled Children	Enrolled Children w/ Claims	Enrolled Children	Enrolled Children w/ Claims
Apr	6,548	1,349	3,413	154
May	6,534	1,466	3,469	162
Jun	6,665	1,580	3,512	169
Jul	6,811	1,653	3,552	164
Aug	6,899	1,476	3,574	156
Sep	7,012	873	3,570	95
Q3 Avg	**6,582**	**1,465**	**3,465**	**162**
Q4 Avg	**6,907**	**1,334**	**3,565**	**138**

This table includes data from the 3rd and 4th Quarters; however, the data from August and September is still within the 90-day claim lag period. Data from both quarters continues to be impacted by the COVID-19 pandemic, which likely resulted in significantly decreased utilization and or claiming. This data will continue to be reviewed in relation to the claim lag, and data will continue to be analyzed to understand the impact of the pandemic, especially in relation to utilization.

VI. Evaluation of the Demonstration

During this quarter ending September 30, three Independent Evaluations (IE) are now ongoing. Over the last year, the Rand Corporation was selected through two separate NYS Dept. of Health competitive procurement processes to conduct the 1115 IE, as well as, the Health and Recovery Program (HARP) and Self Directed Care (SDC) pilot program Independent Evaluations. The fourth independent evaluation for the Children's waiver along with administrative activities related to the other three IE programs over the last nine months, were impacted by the priorities

of the COVID-19 pandemic in NYS. NYS DOH staff, resources and priorities were realigned to COVID-19 response activities and in some cases contract and contract amendments, Data Use Agreements and data inquiries were delayed.

The 1115 Demonstration Waiver Independent Evaluation (IE) research team at Rand was furthest along in data access and analysis. The 1115 IE research team at Rand had prepared preliminary findings on 8 of the Research Questions in Domain 1 and had begun access and data inquiries for the remaining Domain 2 Research Questions. During this quarter ending September 30, the 1115 IE team at Rand was informed that an Interim Independent Evaluation report would be due to CMS next quarter as part of the NYS DOH 1115 Medicaid Waiver extension application. The 1115 IE research team began preparing a draft outline of that 1115 Interim Evaluation report reflecting the preliminary progress to date along with a timeline to continue evaluation activities culminating in an interim evaluation report in the Spring 2021. Weekly progress check in meetings continue to be held with the 1115 researchers at Rand and NYS DOH staff.

The separate HARP and SDC Independent Evaluation contract also with Rand was signed December 2019. During the last nine months, Rand researchers worked to conclude several Data Use Agreements, IRB approval, and conduct weekly meetings with subject matter experts aligned with the NYS HARP and SDC programs. These staff are from the Office of Health Insurance Programs (OHIP), Office of Quality and Patient Safety (OQPS), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) and the Division of Operations and Systems (DOS). Rand researchers prepared a data matrix for each of the 17 HARP and 12 SDC research questions and began to gain access to the data platform where data tables for each of the research questions began to be loaded during this quarter. Also, during this quarter ending September 30, the HARP and SDC IE team at Rand was informed that an Interim Progress Independent Evaluation report would be due to CMS next quarter as part of the NYS DOH 1115 Medicaid Waiver extension application. The HARP and SDC IE research team at Rand began preparing a draft outline of that Interim Progress Evaluation report. As data access to the numerous data sources, had just begun this 4th quarter for the HARP and SDC Rand IE team, no preliminary findings will yet be available. However, weekly progress and check-in meetings continue to be held with the HARP and SDC researchers at Rand and OHIP, OQPS, OMH, OASAS, and DOS representatives and activities are accelerating. A timeline has been developed to fulfill the data access, data analysis and interpretation concluding with an interim evaluation report expected Spring 2021.

As of September 30, the Children's Waiver Independent Evaluation activities are pending a completed procurement process with an independent evaluator contractor. Once that contract is signed by both the vendor and DOH, expected in October 2020, evaluation activities are anticipated to move quickly with an interim evaluation report expected Spring 2021.

VII. Consumer Issues

A. MMC, HARP and HIV SNP Plan Reported Complaints

Medicaid managed care organizations (MMCOs), including mainstream managed care plans (MMCs), Health and Recovery Plans (HARPs), and HIV Special Needs Plans (HIV SNPs) are required to report the number and types of member complaints they receive on a quarterly basis.

The following table outlines the complaints plans reported by category for the most recent quarter and for the last four (4) quarters:

MMCO Product Line	Total Complaints	
	FFY 20 Q4 7/1/2020- 9/30/2020	Last 4 Quarters 10/1/2019-9/30/2020
Medicaid Managed Care	7,287	25,578
HARP	882	2,762
HIV SNP	98	544
Total MMCO Complaints	**8,267**	**28,884**

As described in the table, total MMCO complaints/action appeals reported for the current quarter total 8,267. This represents a 30.1% increase from the prior quarter's total of 6,354. The Department notes that the reason for this large increase is due to a higher than expected increase reported by Molina Healthcare, resulting from the transition of Medicaid members from YourCare Health Plan, which ended operations 6/30/2020. Molina reported 1,244 complaints this quarter compared to 325 last quarter (an increase of 282.8%). Preliminary analysis shows a portion of this increase was related to member's questioning the transition from YourCare to Molina and complaint reporting errors; the Department is in discussion with the plan to confirm member access to care during this period, and determine the need for corrective actions.

This quarter's plan-reported complaint data shows an increase of 28.2% for MMCs from the previous quarter's total of 5,684. HARPs show an increase of 53.7% from the previous quarter, which totaled 574. The majority of the increase for HARP complaints can be attributed to the MMCO transition mentioned above, and an increase in complaints stemming from Difficulty with Obtaining: Personal Care and Difficulty with Obtaining: Home Health Care.

This quarter's HIV SNP complaints saw an increase of 2.1% when compared to the previous quarter's total of 96.

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

Description of Complaint	Percentage of Complaints	
	FFY 20 Q4 7/1/2020-9/30/2020	Last 4 Quarters 10/1/2019-9/30/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	18%	15%
Balance Billing	17%	20%
Reimbursement/Billing	9%	9%
Difficulty with Obtaining: Dental/Orthodontia	9%	7%
Dissatisfied with Quality of Care	7%	6%

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

Description of Complaint	Percentage of Complaints	
	FFY 20 Q4 7/1/2020-9/30/2020	Last 4 Quarters 10/1/2019-9/30/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	22%	17%
Difficulty with Obtaining: Personal Care	13%	7%
Dissatisfaction with Quality of Care	10%	9%
Difficulty with Obtaining: Dental/Orthodontia	7%	6%
Pharmacy/Formulary	7%	16%

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

Description of Complaint	Percentage of Complaints	
	FFY 20 Q4 7/1/2020-9/30/2020	Last 4 Quarters 10/1/2019-9/30/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	17%	22%
Difficulty with Obtaining: Dental/Orthodontia	15%	9%
Dissatisfied with Quality of Care	7%	8%
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	6%	7%
Pharmacy/Formulary	6%	13%

Monitoring of Plan Reported Complaints
The Department engages in the following analysis to identify trends and potential problems.

The observed/expected ratio is a calculation for each MMCO, which represents a comparison of the number of observed complaints to the number that were expected, based on the MMCO's average enrollment for the quarter as a portion of total enrollment for all MMCOs. For example, an observed/expected of 6.15 means that there were more than six times the number of complaints reported than were expected. An observed/expected of 0.50 means that there were only half as many complaints reported as expected.

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

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

Affinity Health Plan FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	2.7	Majority of the complaints in both quarters were related to enrollment issues, members felt they were being incorrectly dis-enrolled. However, disenrollments were appropriate.	Affinity provides re-education on enrollment and eligibility status to members, which includes guidance on contacting the New York State of Health (NYSOH) to review income guidelines or other changes that affect their active coverage with the Plan. This action plan appears to have been effective given that it resulted in this ratio being cut by more than half (5.2 vs 2.0) as compared to the previous reporting period. The Department will continue to monitor this progress in future reporting on the plan's complaints. Note that during the public health emergency, the State halted disenrollment from MMC plans to comply with the Families First Coronavirus Response Act.

Amida Care FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	16.0	The plan identified lack of time designated to member/patient by the provider to address their treatment/management of physical concerns, insufficient or lack of communication between patient and physician/site staff, and lack of clear expectations from the	The plan hired a new Director of Quality starting October 2020. They will collaborate with Provider Services, Member Services, Health and Pharmacy services to implement the corrective action plan. The plan's Provider Services Department will conduct site visits to better educate its providers on its patient's needs. The plan will re-educate all

		provider and site staff to the patient and lack of clear expectations from the patient to the provider and site staff.	providers to deliver culturally competent services to the plan's members. The plan's corrective action plan will ensure that providers, clinical and ancillary staff are provided with the support and tools needed to assist with the management of the plan's member population.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	13.6	Complaints received regarding network DME vendors not meeting delivery standards; providers not meeting cultural sensitivity / customer service standards interacting with members. Complaints received regarding service from DME staff.	The plan will re-educate DME vendors on meeting member satisfaction and routine delivery times; re-educate provider network on cultural sensitivity / customer service, including audits and site visits; conduct staff customer service training on member benefits and programs. The Department is meeting with the plan to determine a more effective plan of action due to this category's persistently high complaint o/e ratio.
Difficulty with Obtaining: Dental/ Orthodontia	9.9	Complaints received regarding dental offices being unclean, dental office staff being rude. Providers and members unclear on dental benefits. Providers not accepting Amida Care coverage. Consumer dissatisfaction with Healthplex Customer Service Representative.	Dental vendor provided participating providers with three different educational videos on their portal site. These videos are expected to decrease the number of complaints regarding professionalism of doctors and staff. Continue to provide dental benefit information in town hall meeting, member newsletter, and e-blast dental brochure; provide quality improvement education to providers through calls, letters and office visits. All dental complaints will continue to be reviewed at the plan's Delegated Vendor Oversight meetings. The Department is in discussions with the plan on additional actions to decrease dental complaints as this category has

			shown little improvement from previous period.
Pharmacy\Formulary	14.8	Large jump in the number of Pharmacy and Formulary complaints ratio (from two times to six times). Possible causes include combination of fraud, medication denials and customer service issues.	Pharmacy auditor conducted desk audit that led to a Fraud Waste Abuse audit which resulted in one pharmacy being removed from the plan's network. Education videos created for provider education dealing with refills, pharmacy benefits, medication denials and customer service issues. NYSDOH will closely monitor to determine if the action plan being enacted is effective in bringing down those complaint totals in the next reporting period. This category has increased from the 2.1% reported from the previous period.
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	60.3	Members not receiving replacement cards, unclear on program rules regarding enrollment requirements and timely receipt of benefit program incentives.	Plan conducted provider outreach (via site visits, webinars and conference calls) to improve education on benefit program incentives in order to ensure program engagement and understanding. Plan improved benefit card replacement process turnaround time to 7-10 business days and is now working towards automation process for further improved turnaround times. Plan has launched redesigned website, new member mobile app and is updating its member brochures. This complaint category decreased 4 percentage points from last quarter. However, NYSDOH will monitor this action plan closely as this ratio continues to be higher than the expected level of complaints.

Excellus Health Plan FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	4.0	Complaints regarding Eye Care denied in accordance with benefits and fee schedule but overturned when medical necessity was determined.	Routine vision exam and eyewear benefits correctly denied due to two-year benefit renewal parameter. Denial overridden with provider giving Plan the supporting medical necessity reason to override 2-year window. Plan will reach out to providers to remind them of their grievance rights regarding these types of claim denials.
Difficulty with Obtaining: Dental/ Orthodontia	2.9	Complaints regarding denial of dental services not covered by Medicaid managed care.	Plan will re-educate dental providers on what pre authorizations and criteria are required for root canals, crowns and dentures according to NYS Dental Manual Guidelines. Plan denials have been upheld in close to 90% of the cases involving this category. The Department will continue to monitor progress in the next reporting period.

Healthfirst FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	3.0	The plan identified an increase in complaints related to DME supplies. Upon investigation it was determined that the root cause of this spike in complaints was related to an issue with its largest DME vendor.	The plan is actively working to improve member satisfaction with DME supply related issues. It has taken a series of proactive steps to mitigate the number of complaints captured in this category including but not limited to established a collaborative workgroup between itself and the DME vendor; established weekly meetings with the DME leadership to address identified issues, and process

			improvements; implemented weekly submission of complaints to the DME vendor for review, analysis, and feedback; obtained access to CLEAR, the DME vendor's tracking platform, granting us transparency into existing orders and their status; the DME vendor committed to and performed increased provider monitoring and oversight of their network; and as of September the DME vendor implemented a dedicated client service line for the plan to promote a consistent, standard-operating procedure, and an enhanced health plan experience. NYSDOH will continue to monitor this category.
Difficulty with Obtaining: Specialist and Hospitals	3.5	During COVID pandemic, members experienced many provider offices closures and limited access to hospitals and/or specialists.	As appropriate, members were referred to an alternate provider site, or an urgent care center for non-emergency related services. Members were encouraged to contact their primary care provider or specialist to discuss telemedicine as an option to obtain treatment. Healthfirst's network team ensured telehealth services were enabled and providers equipped to deliver care virtually as a result of the COVID-19 pandemic. NYSDOH will continue to monitor this category to ensure access to care.
Pharmacy\Formulary	2.9	In February 2020, members received notification regarding a change in the quarterly maximum out of pocket (MOOP) beginning 04/01/2020. There was an increase of member calls during March-	Complaints related to the MOOP change are not expected to continue. To correct reporting issues, the plan will provide further clarification in the work instructions utilized by customer care agents and continue agent monitoring and coaching. NYS DOH will continue to monitor

		May due to the members not fully understanding how this change impacted their pharmacy benefit. The plan also reported agents were incorrectly identifying inquiries as complaints, which incorrectly inflated the number of pharmacy/formulary complaints reported.	this complaint category.
All Other	2.0	The plan conducted a review of the items in this category, which revealed that there were some items that could have been better categorized.	The plan will conduct a review of data mapping in its new Appeals and Grievances (A&G) processing system to add more refinement to these classifications. Upon completing this mapping effort, the plan will train staff on the system enhancements related to complaint categorization. The plan will align its quality assurance program to these updates. It expects this effort to be completed by the end of November. Once the plan obtains specificity on the types of complaints captured under the category heading, it will be able to note related trends and develop appropriate action plans as needed. NYSDOH will monitor the effectiveness of this action plan vs. future quarter observed observed/expected ratios.
Difficulty with Obtaining: RHCF Services	3.4	The plan identified that member inquiries were incorrectly reported as complaints; complaints were miscategorized.	The plan is improving their complaint intake and classification process by increasing supervisory oversight of the call intake team and re-education and ongoing training of their Appeals and Grievances

			(AG) staff. The Department is in discussions with the plan regarding these improvements, assuring correct identification and categorization of complaints, and reviewing issues raised by enrollees during such contacts with the plan, particularly those concerning LTSS.
Difficulty with Obtaining: Home Health Care	2.9	As a result of COVID-19, the ability to provide consistent home health care services for some of our members was impacted. Home Health Care providers and aides experienced appointment challenges including but not limited to, PPE shortages, member refusal of aides in their homes, aides experiencing delays with travel, and sufficient staffing by Home Health Care providers.	Upon receipt of a home care complaint, the Appeals and Grievances team conducts a quality assurance review of the complaint. Cases are reviewed to ensure access to care was addressed and appropriate outreach was conducted to the member. The plan's Delivery System Engagement team addressed instances where home health care providers fell short of service expectations. NYSDOH will monitor the effectiveness of this action plan to ensure continued access to care.
Difficulty with Obtaining: Personal Care	4.2	As a result of COVID-19, the ability to provide consistent home health care services for some of our members was impacted. Home Health Care providers and aides experienced appointment challenges including but not limited to, PPE shortages, member refusal of aides in their homes, aides	Upon receipt of a home care complaint, the Appeals and Grievances team conducts a quality assurance review of the complaint. Cases are reviewed to ensure access to care was addressed and appropriate outreach was conducted to the member. The plan's Delivery System Engagement team addressed instances where home health care providers fell short of service expectations. NYSDOH will monitor the effectiveness of this action plan to ensure access

		experiencing delays with travel, and sufficient staffing by Home Health Care providers.	to care.
Difficulty with Obtaining: CDPAS	4.3	Common issues related to delays with the completion of the CDPAS paperwork with the Fiscal Intermediaries (FI).	Plan will continue to work with the Healthfirst Care Managers to ensure review of issues related to agency identification and CDPAS paperwork compliance. NYS DOH will monitor the effectiveness of this CAP vs. future quarter observed observed/expected ratios.
Dissatisfaction with Behavioral Health Provider Services	2.1	Due to the COVID-19 pandemic, members experienced the impact of provider office closures and limited access to behavioral health services for non-urgent appointments.	Members were encouraged to contact their primary care provider or BH provider to discuss telemental health services as an option to obtain treatment. Healthfirst's network team ensured telemental health services were enabled and providers equipped to deliver care virtually as a result of the COVID-19 pandemic. NYS DOH will monitor the effectiveness of this action plan vs. future quarter observed observed/expected ratios.
Dissatisfaction with Health Home Care Management	3.0	The plan identified that identified that a significant portion of complaints in this category were incorrectly classified.	The plan will conduct a review of data mapping in its new A&G processing system to add more refinement to these classifications. Upon completing this mapping effort, the plan will train staff on the system enhancements related to complaint categorization. The plan will align its quality assurance program to these updates. It expects this effort to be completed by the end of November. Once the plan obtains specificity on the types of

			complaints captured under the category heading, it will be able to note related trends and develop appropriate action plans as needed. NYSDOH will monitor the effectiveness of this action plan vs. future quarter observed observed/expected ratios.

HealthNow **FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)**			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	2.4	Plan reports the primary root cause of higher than anticipated complaints is based on member perceptions of the dental benefit.	100% of the complaints are ultimately determined to be unfounded/non-substantiated. Plan will provide additional education, materials, criteria and training to their frontline staff, as well as members, regarding which dental services are covered and which are not covered by NYS Medicaid managed care. The Department will continue to monitor the effectiveness of this action plan.

HealthPlus **FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)**			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	3.7	Primary root cause of higher than anticipated complaints appears to be based on member misunderstanding of the dental benefit.	98% of the complaints are ultimately determined to be unfounded/non-substantiated. The plan will develop additional resources and instructions for front line staff in the various Member Service Units to better educate members and achieve member satisfaction through first call resolution. NYSDOH will follow progress in future quarters.

Health Insurance Plan of Greater New York FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Reimbursement/Billing	2.3	Plan conducted a root cause analysis on the reimbursement/billing complaints and found the top issue was members mistaking their EOB for a bill.	The plan is increasing communication to the members on EOB's to ensure they are aware that the EOB is not a bill and the member is not liable for the denial. NYSDOH will continue to monitor this category.

Independent Health Association FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	4.9	No trends identified with any one provider.	The plan's customer service department performed retraining with all applicable associates regarding the importance of logging complaints, specifically, identifying quality complaints during phone conversations. The plan is reviewing the process for complaints immediately resolved to help identify process improvements. NYSDOH will continue to monitor this category for improvement.
Difficulty with Obtaining: Dental/ Orthodontia	4.6	Complaints and action appeals were related to the limited benefit coverage for dental services. There were few complaints with respect to the quality of care or service received at the dentist.	NYSDOH is in discussions with the plan to develop corrective actions to address this category.
Pharmacy\Formulary	7.6	A majority of the complaints and appeals were in regard to prior authorization requirements and non-covered medications.	The plan is reviewing the process for complaints immediately resolved to help identify process improvements. NYSDOH will continue to monitor this category for improvement.

		The vast majority of the complaints and action appeals were immediately resolved at the time of the call.	
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	11.1	The majority of complaints were regarding members wanting to change their PCP from what was listed on their ID card.	The plan is implementing a process to better align the issuance of ID cards with the member's PCP selection. With this process improvement, it expects the trend regarding ID cards and PCP changes to reduce. NYSDOH will monitor the effectiveness of this corrective action.
All Other	6.4	Plan review of the complaints and action appeals revealed complaints regarding ID cards and enrollment issues outside of Independent Health's control; complaints related to the IVR system; PCP changes; and complaints with respect to not being able to release PHI without a valid HIPAA authorization or written consent.	The plan is reviewing its complaints process as multiple complaints that were miscategorized. NYSDOH will continue to monitor trends in this category.

MetroPlus Health Plan FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	2.6	Complaints due to vision providers who attempted to charge members for replacement glasses as they presumably believed the plan would not cover the cost. Some claims for replacement glasses were	The plan educated providers involved in these cases about vision coverage and appropriate billing practices, including plan resources for questions or concerns on benefits and payment of claims, and to cease attempting to charge members. The Department will

		denied as providers failed to use the correct modifier when billing. In addition, when replacements were obtained by a provider who was no longer available, the new provider would refer the member back to the original provider for services.	continue to monitor the effectiveness of these measures and member access to services.
Difficulty with Obtaining: Emergency Services	8.5	Complaints regarding member billing for emergency services were related to two contributing factors: (1) hospitals claimed not to have adequate insurance information and (2) hospital billing errors.	The recurrent trends identified in these cases were associated with facilities not capturing insurance information appropriately, members failing to present Plan ID cards or providing outdated information at the time of ER visit, charges being applied to the patient (member) and not to the insurance plan and delays in applying claim payments to accounts. MetroPlus Health Plan will continue to conduct provider education on adequate verification of eligibility and appropriate billing practices; include billing articles in provider newsletters and on the plan's provider portal; and continue to educate members to carry their ID cards and show this ID whenever they are seeking services. Further, the plan will revise the complaint intake and review process to gain a better understanding of why members are billed to develop preventive actions to decrease occurrences. NYS DOH will continue to monitor the progress of this action plan.
Balance Billing	5.5	Complaints regarding member billing were related to two contributing factors: (1) hospitals claimed not to have adequate insurance information and (2) hospital	The recurrent trends identified in these cases were associated with facilities not capturing insurance information appropriately, members failing to present Plan ID cards or providing outdated information

		billing errors.	during visits, charges being applied to the patient (member) and not to the insurance plan and delays in applying claim payments to accounts. MetroPlus Health Plan will continue to conduct provider education on adequate verification of eligibility and appropriate billing practices; include billing articles in provider newsletters and on the plan's provider portal; and continue to educate members to carry their ID cards and show this ID whenever they are seeking services Further, the plan is revising the complaint intake and review process to capture more information and gain a better understanding of why members are billed to develop preventive actions to decrease occurrences. NYS DOH will continue to monitor trends in this category of complaint.

Molina Healthcare FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	6.2	Complaints related to termination of Walgreen's Pharmacy participation in the plan's network.	Molina provided member notice education prior to the pharmacy provider change, however members continued to access Walgreen's pharmacy. The plan conducted additional communication, outreach and notices were issued to mitigate the pharmacy complaints, including to new members. Molina also has provided education and materials to providers to direct members and prescriptions to participating pharmacies. The Department will follow up with the plan

			regarding correct complaint categorizing for these issues and effectiveness of this action plan.
Difficulty with Obtaining: Specialist and Hospitals	3.5	The plan identified complaints regarding access issues related to Dermatologists and Neurologists.	Molina is reviewing this complaint trend at the Peer Committee level and weekly reporting and reaching out to highly utilized out of network providers to offer provider contracts. Molina also acquired a larger network and anticipates improved access to care. Molina will also work closer with the referring providers, to direct members to participating specialists. The Department will monitor this action plan for effectiveness in improving access to care.
Pharmacy\Formulary	3.5	Complaints regarding lack of prior authorization where required and/or denial for formulary alternatives.	The plan improved education materials for providers regarding pharmacy prior authorization requirements; the plan continues to experience an increase in PA denials due to pertinent clinical information that is not being provided with the initial request. The plan also continues to send prior authorization expiration notices to members and providers. The plan has also retrained and revised call center talking points for pharmacy in order to improve the member experience NYSDOH will continue to monitor progress of this action plan in light of the planned transition of the pharmacy benefit to Medicaid FFS 04/01/2021.
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	15.6	Complaints related to 1) members stating providers had incorrect information regarding	For the first issue related to the providers providing eligibility information, Molina will reeducate providers on how to

		their eligibility, and 2) the plan erroneously sending notice of "Failure to Recertify" to members.	confirm member eligibility. Molina implemented a corrective action plan to resolve the erroneous member notice, including halting the letter processing, and educating the member contact center and facilitated enrollment team to ensure that members were notified to ignore the letter. NYS DOH to meet with Plan to discuss this action plan and monitor progress in resolving these issues.
All Other	25.6	Molina identified the largest sub-categories within "Other" as related to member ID cards and HCS/UM Related (authorization turnaround time, PA Requirements).	At the end of 2019, the plan had identified and corrected an ID card issue related to the address verification system used by a former vendor, and the impact of this correction began to take effect in lower complaints related to ID cards in 2020. The majority of HCS/UM Related (authorization turnaround time, PA Requirements) complaints were resolved immediately. The NYSDOH will discuss correct reporting and categorization of complaint reporting with the plan and continue to monitor this corrective action.
Balance Billing	5.6	Providers erroneously billing members as they were unaware the member had Molina coverage, or billing office is unaware of standard billing. Other complaints were related to members' misinterpreting EOBs.	Some complaints were related to out of network providers. Molina will continue to monitor the internal reports and educate and re-educate the providers on balance billing prohibitions and educating members on interpreting EOBs. NYSDOH will continue to monitor this action plan.

MVP Health Plan FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	3.6	During the first half of 2020, MVP reported most dental complaints related to the limited dental benefit were unsubstantiated, and few appeals were overturned, consistent with previous experience.	Enrollment in the first half of 2020 vs. the first half of 2019 was virtually unchanged (down 0.5%), while complaints/appeals were down 49.4% Q1 '19-Q1 '20 (prior to the onset of COVID-19), and down 76.3% Q2 '19-Q2 '20 (with COVID contributing to the substantial decline). Because the complaint trend was positive and no consistent issues were identified, no action plan is required at this time. The NYSDOH will continue to monitor this trend.

United Healthcare FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.8	Complaints related to the provider not providing the patient with the results of tests performed, or the provider not returning the member's call.	The majority of complaints were unsubstantiated, and no trend was identified with a specific provider. NYSDOH will continue to monitor this category.
Denial of Clinical Treatment	9.3	The majority of complaints were related to the limited dental benefit and related dental denial appeals, and the majority of cases were upheld.	The plan is working to improve provider education on covered dental benefits when service authorizations are requested. The Department is working with the plan to improve their reporting of dental issues in the appropriate category and will continue to monitor this trend.
Problems with Advertising\Consumer Education\Outreach\ Enrollment	2.4	Of the complaints submitted, 22% of the concerns related to cancelation of	NYSDOH is following up with the plan regarding coverage cancellation and premium complaints to confirm accurate

		coverage, 19% of the concerns related to a premium rate change. The majority of closed cases were substantiated (58%).	complaint reporting as no enrollee premiums are applicable to Medicaid managed care programs in NYS.
Balance Billing	2.6	Complaints due to receiving a bill from the provider.	Upon review, the plan determined that for 40% of these complaints the member received a statement of charges, not a bill. For 13% of the complaints the provider of service indicated the member would continue to be billed, and the plan sent a Cease and Desist Letter. NYSDOH will discuss with the plan additional actions to take to mitigate provider balance billing.

VNS Choice FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	9.5	Complaints regarding lack of follow up, delays or difficulties in receiving services, long wait times, and unprofessionalism. There were no issues or trends identified amongst the complaints. However, some complaints were miscategorized.	The plan provided reeducation to staff on complaint categories and the plan's Quality Review team will conduct monthly monitoring to prevent this from occurring again in the future. NYSDOH will continue to monitor this category.
Reimbursement/Billing	12.7	The plan reported multiple complaints were incorrectly recorded here, instead of under Balance Billing.	The member services team who handle same day grievances were reeducated. The team will to monitor calls daily going forward to ensure the correct category is selected. NYSDOH will monitor the effectiveness of this corrective action.

WellCare* FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Emergency Services	8.8	Complaints due to Providers not having the member ID, members visiting out of state emergency rooms and providers generating a bill to the member before the claim is processed by the plan.	Out of State providers have been unwilling to work with the plan to submit a claim and to stop billing the member. In State providers have been re-directed to bill plan. NYSDOH will monitor this category for continuing trends post transition to Fidelis Care.
Reimbursement/Billing	4.4	Complaints due to providers billing incorrect TIN which results in denial, labs denials for no auth because they are non-par. Members having other primary insurance. Claim denials for incorrect coding.	The plan reports providers use labs without checking to see if they are par with the plan. Providers are not submitting corrected claims to address denials, when appropriate. NYSDOH will monitor this category for continuing trends post transition to Fidelis Care.
Balance Billing	3.7	Complaints related to balance billing.	The plan determined that in some cases the member ignores the provider's attempts to obtain ID and as a last resort the provider sends the member a bill; alternately provider receives plan payment and automatically send member the remainder of the bill. NYSDOH will monitor this category for continuing trends post transition to Fidelis Care.

YourCare Health Plan** FFY 20 Q2–FFY 20 Q3 (1/1/2020–6/30/2020)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Denial of Clinical Treatment	6.4	Complaints/appeals related to the limited	Similar overall trends from the previous year for dental procedures

		dental benefit.	that are not a covered benefit. The plan provides continuous education to members and providers regarding covered dental benefits. NYSDOH will monitor this category for continuing trends post transition to Molina.
Reimbursement/Billing	13.3	The majority of these complaints are grievances for claims that are denied due to untimely filing. There were also grievances for out of network provider billings for services with no authorization on file or obtained.	The plan educated providers around timely filing of claims and plan authorization requirements, and also corrected claim processing issues. NYSDOH will monitor this category for continuing trends post transition to Molina.

*Effective June 1, 2020 WellCare was acquired by Fidelis Care.
**Effective June 30, 2020 YourCare was acquired by Molina Healthcare
NYSDOH will follow-up with the acquiring plan on ongoing issues needing to be addressed from the acquired plan as appropriate.

Long Term Services and Supports (LTSS)
As SSI members typically access long term services and supports, the Department monitors complaints and action appeals filed for this product line with managed care plans. Of the 8,267 total reported complaints/action appeals, mainstream MMCOs reported 1,314 complaints and action appeals from their SSI members. This compares to 1,330 SSI complaints/action appeals from the previous quarter, representing a 1.2% decrease.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Members	
	FFY 20 Q4 7/1/2020-9/30/2020	Last 4 Quarters 10/1/2019-9/30/2020
Appointment Availability: PCP	22	26
Appointment Availability: Specialist	9	14
Appointment Availability: BH HCBS	0	0
Long Wait Time	5	11
Dissatisfied with Quality of Care	80	292
Denial of Clinical Treatment	31	103
Denial of BH Clinical Treatment	0	3
Dissatisfied with Provider Services (Non-Medical) or MCO Services	475	1,382
Dissatisfaction with BH Provider Services	1	10
Dissatisfaction with Health Home Care Management	1	103
Difficulty with Obtaining: Specialist and Hospitals	16	239
Difficulty with Obtaining: Eye Care	5	9
Difficulty with Obtaining: Dental/Orthodontia	39	193
Difficulty with Obtaining: Emergency Services	6	22
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	1	69
Difficulty with Obtaining: RHCF Services	0	20
Difficulty with Obtaining: Adult Day Care	1	3
Difficulty with Obtaining: Private Duty Nursing	18	23
Difficulty with Obtaining: Home Health Care	77	118
Difficulty with Obtaining: Personal Care	208	476
Difficulty with Obtaining: PERS	8	11
Difficulty with Obtaining: CDPAS	60	261
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0

Pharmacy/Formulary	46	167
Access to Non-Covered Services	11	69
Access for Family Planning Services	0	0
Communications/ Physical Barrier	5	8
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	17	32
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	42	174
Balance Billing	66	271
Transportation	27	63
All Other	37	412
Total	**1,314**	**4,584**

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

Description of Complaint	**Percentage of Total Complaints/Appeals Reported for SSI Members**	
	FFY 20 Q4 7/1/2020-9/30/2020	**Last 4 Quarters 10/1/2019-9/30/2020**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	36%	30%
Difficulty with Obtaining: Personal Care	16%	10%
Dissatisfied with Quality of Care	6%	6%
Difficulty with Obtaining: Home Health Care	6%	3%
Balance Billing	5%	6%

The Department requires MMCOs to report the number of members in receipt of LTSS as of the last day of the quarter. During the current reporting period of July 1, 2020 through September 30, 2020, MMCOs reported LTSS enrollment of 39,799 members. This compares to 37,386 members from the previous quarter, representing a 6.5% increase. The following table outlines the number of LTSS members by plan for each of the last four (4) quarters:

Plan	Number of LTSS Members			
	FFY 20 Q4 7/1/2020-9/30/2020	**FFY 20 Q3 4/1/2020-6/30/2020**	**FFY 20 Q2 1/1/2020-3/30/2020**	**FFY 20 Q1 10/1/2019-12/31/2019**
Affinity Health Plan	475	764	925	1,346
Amida Care	1,427	966	1,140	1,327
Capital District Physicians Health Plan	596	424	436	443
Excellus Health Plan	1,519	1,429	1,371	1,414
Healthfirst	9,546	10,030	9,979	9,134
HealthNow	175	159	160	145
HealthPlus	2,878	2,624	2,865	2,596
Health Insurance Plan of Greater New York	373	394	357	385
Independent Health Association	441	414	406	414
MetroPlus Health Plan	3,490	2,613	2,679	2,086
Molina Healthcare	1,122	490	554	17
MVP Health Plan	1,559	1,474	1,406	1,357
Fidelis Care	13,249	11,909	10,954	10,667
United Healthcare	2,608	2,445	2,452	2,426
VNS Choice	341	330	355	348
WellCare*	0	500	498	470
YourCare Health Plan**	0	421	387	381
Total	**39,799**	**37,386**	**36,924**	**34,956**

*Effective June 1, 2020 WellCare is no longer a NYS MMCO

**Effective June 30, 2020 YourCare is no longer a NYS MMCO

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

Description of Complaint	Number of Complaints/Action Appeals Reported			
	FFY 20 Q4 7/1/2020-9/30/2020	FFY 20 Q3 4/1/2020-6/30/2020	FFY 20 Q2 1/1/2020-3/30/2020	FFY 20 Q1 10/1/2019-12/31/2019
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0	1	0
Difficulty with Obtaining: Adult Day Care	2	1	2	2
Difficulty with Obtaining: CDPAS	118	168	176	18
Difficulty with Obtaining: Home Health Care	146	33	56	41
Difficulty with Obtaining: RHCF Services	5	35	35	18
Difficulty with Obtaining: Personal Care	442	231	227	47
Difficulty with Obtaining: PERS	14	1	5	0
Difficulty with Obtaining: Private Duty Nursing	21	5	1	0
Total	**748**	**474**	**503**	**126**

The above documented increase in complaints regarding Difficulty with Obtaining: Home Health Care and Difficulty with Obtaining: Personal Care is identified as being due to one MMCO's increase in complaints within these categories. The Department is actively working with the MMCO, Healthfirst, and monitoring its improvement within these areas.

B. Critical Incidents:

The Department requires MMCOs to report critical incidents involving members in receipt of LTSS. There were 73 critical incidents reported for the July 1, 2020 through September 30, 2020 period, most of which have a resolved status. Many of the incidents stemmed from falls or were related to COVID-19. The Department continues to work with MMCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

The following table outlines the total number of LTSS critical incidents reported by MMC, HARP, and HIV SNP for each of the last two (2) quarters, the net change over the last two (2) quarters, and the total for the last four (4) quarters:

Plan Name	Critical Incidents			
	FFY 20 Q4 7/1/2020–9/30/2020	FFY 20 Q3 4/1/2020–6/30/2020	Net Change	Last 4 Quarters 10/1/2019–9/30/2020
Mainstream Managed Care				
Affinity Health Plan	0	1	-1	1
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	4	16	-12	35
Fidelis Care	0	0	0	0
Healthfirst	31	9	+22	65
Health Insurance Plan of Greater New York	0	0	0	0
HealthNow	0	0	0	0
HealthPlus	2	2	0	4
Independent Health Association	0	0	0	0
MetroPlus Health Plan	0	1	-1	1
Molina Healthcare	0	0	0	0
MVP Health Plan	4	1	+3	6
United Healthcare	0	0	0	0
WellCare	0	17	-17	35
YourCare Health Plan	0	1	-1	7
Total	**41**	**48**	**-7**	**154**
Health and Recovery Plans				
Affinity Health Plan	0	0	0	0
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	4	0	+4	4
Fidelis Care	0	0	0	0
Healthfirst	25	17	+8	165
Health Insurance Plan of Greater New York	0	0	0	0
HealthPlus	0	0	0	0
Independent Health Association	0	0	0	0
MetroPlus Health Plan	0	0	0	0

Molina Healthcare	0	0	0	0
MVP Health Plan	1	0	+1	1
United Healthcare	0	0	0	0
VNS Choice	2	2	0	4
YourCare Health Plan	0	1	0	1
Total	**32**	**20**	**+12**	**175**
HIV Special Needs Plans				
Amida Care	0	0	0	0
MetroPlus Health Plan	0	0	0	0
VNS Choice	0	1	-1	6
Total	**0**	**1**	**-1**	**6**
Grand Total	**73**	**69**	**+4**	**335**

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

Category of Incident	**Critical Incidents**			
	FFY 20 Q4 7/1/2020–9/30/2020	**FFY 20 Q3 4/1/2020–6/30/2020**	**Net Change**	**Last 4 Quarters 10/1/2019–9/30/2020**
Mainstream Managed Care				
Any Other Incidents as Determined by the Plan	0	6	-6	15
Crimes Committed Against Enrollee	2	4	-2	11
Crimes Committed by Enrollee	3	1	+2	8
Instances of Abuse of Enrollees	11	6	+5	20
Instances of Exploitation of Enrollees	0	0	0	1
Instances of Neglect of Enrollees	1	1	0	8
Other Incident Resulting in Hospitalization	9	20	-11	44
Other Incident Resulting in Medical Treatment Other Than Hospitalization	15	4	+11	40
Wrongful Death	0	6	-6	7
Total	**41**	**48**	**-7**	**154**

Health and Recovery Plans				
Any Other Incidents as Determined by the Plan	2	1	+1	3
Crimes Committed Against Enrollee	1	1	0	5
Crimes Committed by Enrollee	2	0	+2	3
Instances of Abuse of Enrollees	0	0	0	1
Instances of Exploitation of Enrollees	1	0	+1	1
Other Incident Resulting in Hospitalization	4	5	-1	33
Other Incident Resulting in Medical Treatment Other Than Hospitalization	21	13	+8	125
Use of Restraints	1	0	+1	4
Total	**32**	**20**	**+12**	**175**
HIV Special Needs Plans				
Instances of Abuse of Enrollees	0	1	-1	1
Instances of Neglect of Enrollees	0	0	0	1
Other Incident Resulting in Hospitalization	0	0	0	1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	0	0	0	3
Total	**0**	**1**	**-1**	**6**
Grant Total	**73**	**69**	**+4**	**335**

C. Member Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 53 member complaints this quarter. This total is a 5.4% decrease from the previous quarter, which reported 56 member complaints.

Annually, the Department directly received 293 MMCO member complaints regarding Medicaid managed care, HARPs and HIV SNPs. The following chart represents previously reported complaints filed directly with NYSDOH, including complaints from members and their representatives.

During the COVID-19 emergency, the Department saw a decrease in the number of complaints it directly received. No disruption in the Department's handling or receiving of complaints was identified.

MMCO Member Complaints Received Directly by the Department				
FFY 20 Q4 7/1/2020-9/30/2020	**FFY 20 Q3 4/1/2020-6/30/2020**	**FFY 20 Q2 1/1/2020-3/30/2020**	**FFY 20 Q1 10/1/2019-12/31/2019**	**Total FFY 20 10/1/2019-9/30/2020**
53	**56**	**97**	**87**	**293**

The top five (5) most frequent categories of member complaints received directly at NYSDOH involving MMCOs were as follows:

Percentage of MMCO Member Complaints Received Directly by the Department				
Description of Complaint	**FFY 20 Q4 7/1/2020–9/30/2020**	**FFY 20 Q3 4/1/2020–6/30/2020**	**FFY 20 Q2 1/1/2020-3/30/2020**	**FFY 20 Q1 10/1/2019-12/31/2019**
Reimbursement/Billing	9%	9%	12%	7%
Difficulty with Obtaining: Home Health Care	8%	4%	4%	10%
Difficulty with Obtaining: Dental/Orthodontia	8%	2%	2%	7%
Pharmacy/Formulary	6%	14%	13%	11%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	4%	5%	4%	5%

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

In compliance with the Families First Coronavirus Response Act, loss of Medicaid coverage was suspended on March 18, 2020, unless a member cancelled their coverage or moved out of New York State. Since March, the Department has carefully monitored any complaints regarding suspended loss of Medicaid coverage, and addressed these issues in accordance with maintenance of effort requirements during this period.

D. Fair Hearings

There were 304 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of July 1, 2020 through September 30, 2020. The dispositions of these fair hearings as well as the previous three quarters are as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP)					
Hearing Dispositions	**FFY 20 Q4 7/1/2020-9/30/2020**	**FFY 20 Q3 4/1/2020-6/30/2020**	**FFY 20 Q2 1/1/2020-3/30/2020**	**FFY 20 Q1 10/1/2019-12/31/2019**	**Total FFY 20 10/1/2019-9/30/2020**
In favor of Appellant	119	87	106	168	480
In favor of Plan	148	111	131	219	609
No Issue	37	33	18	42	130
Total	**304**	**231**	**255**	**429**	**1,219**

For fair hearing dispositions occurring during the reporting periods, the following table describes the number of days from the initial request for a fair hearing to the final disposition of the hearing, including time elapsed due to adjournments.

Fair Hearing Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP)					
Decision Days	**FFY 20 Q4 7/1/2020-9/30/2020**	**FFY 20 Q3 4/1/2020-6/30/2020**	**FFY 20 Q2 1/1/2020-3/30/2020**	**FFY 20 Q1 10/1/2019-12/31/2019**	**Total FFY 20 10/1/2019-9/30/2020**
0-29	28	4	0	7	39
30-59	73	48	82	171	374
60-89	36	75	87	133	331
90-119	49	42	38	57	186
=>120	118	62	48	61	289
Total	**304**	**231**	**255**	**429**	**1,219**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on September 17, 2020. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the Medicaid Managed Care program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; and an update on the status of the Managed Long Term Care (MLTC) program. Two additional agenda items included a presentation on the MCO Network Adequacy Standards, and the Mental Health Parity and Addiction Equity Phase II, both presented by staff from the Bureau of Managed Care Certification and Surveillance. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for December 17, 2020.

Annual: The Medicaid Managed Care Advisory Review Panel is required to meet quarterly. Meetings were held on December 19, 2019, February 20, 2020, June 18, 2020, and September 17, 2020.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

In November, the Department release to the MLTC plans, their Crude Percent Reports for the time period of January through June 2019. The Crude Percent Reports provide the plans with a distribution of their members compared to the statewide, for many of the components of the functional assessment tool.

The Crude Percent report provides a breakout by percentage (unless a metric is reported as an average) of each response level for most components of the Community Assessment, Functional Supplement, and Mental Health Supplement across two six-month time periods. Plans were also provided the percentages for the rest of the state with their plan excluded for comparison purposes. Plans were encouraged to review the reports, compare their results to previous data, and look at areas with changes from the previous reporting period to ensure data completeness.

In December, we released to the plans the methodology for the 2020 MLTC Quality Incentive.

In April 2020, as part of the Department's review process for the publication and public release of its annual Report on quality performance by the Managed Long-Term Care (MLTC) plans, we released the DRAFT data to the MLTC plans as an opportunity for the plans to verify their rates.

In May, we updated the dataset **Managed Long-Term Care Performance Data: Beginning 2014** on Health Data NY with January to June 2019 performance data. It can be viewed or downloaded from the following link: https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp/data. Data dictionary, measure definitions, and more for this dataset may be found by clicking on the "About" tab, and then scrolling half way down to find the PDF documentation. Charts may be found by clicking on "More Views."

In May, we also updated the **Managed Long-Term Care (MLTC) Reports** webpage, the MLTC Plan Comparison for New York State (eMLTC) link will connect to the MLTC Performance Tables that present measure results from the most recent January through June and July through December evaluation periods.

In June, we released Crude Percent Reports for the July through December 2019 time period to the Managed Long-Term Care plans. These reports are plan-specific, reflective of each

plan's July through December 2019 cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this six-month time period.

The 2019 MLTC Consumer Guides were released in September 2020 on the Department's website. The Guides are also printed by Maximus, our facilitated Medicaid enroller, for inclusion in new member's packets. The Guides help new members to choose a managed long-term care plan that meets their health care needs. The Guides offer information about the quality of care offered by the different plans, and people's opinions about the care and services the plans provide.

B. Quality Measurement in Medicaid Managed Care

Quality of care remained high for Medicaid Managed Care members for the Demonstration Year. In measurement year 2018 national benchmarks were available for 59 measures for Medicaid. Out of the 59 measures that NYS Medicaid plans reported, 85% of measures met or exceeded national benchmarks. New York State consistently met or exceeded national benchmarks across measures, especially in Medicaid managed care. The NYS Medicaid, rates exceed the national benchmarks for behavioral health on adult measures (e.g., receiving follow-up within 7 and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). New York State managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., prenatal and postnatal care, as well as screening for Chlamydia, and cervical cancer).

The Department conducted a satisfaction survey with adults enrolled in Medicaid managed care in the fall of 2019. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 Adult survey was administered to adults, ages 18 to 64, enrolled in Medicaid Managed Care Plans, HIV Special Needs Plans, and Health and Recovery Plans. The administration methodology consisted of a three-wave mailing protocol, with telephone follow up for non-responders. The overall response rate was 11% (with a range of 7% to 15% for response rates by plan). There has been decline in response rates from the previous survey that was fielded in the Fall of 2017, however we oversampled adults which resulted in more usable responses even though the overall response rate went down. The findings demonstrate that adults have generally high levels of satisfaction with care. There is a statewide summary report for Medicaid Managed Care and HIV Special Needs plans and there are eighteen plan specific reports. The Health and Recovery Plan reports are going through executive review and will be posted here soon. All reports are available here: https://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report/2020/

We had 24 Managed Care Organizations submit Quality Assurance Reporting Requirement (QARR) data on June 15, 2020. The fourteen Qualified Health Plans operating through the NY State of Health Marketplace were not required by CMS to report quality data, but we had them report to NYS so we could continue to monitor their data for quality improvement purposes. Health plan quality measurement reporting was impacted by COVID-19 especially as it relates to measures that medical record data as this was collected during the height of the pandemic and may have suffered from the lack of available resources at both the health plan and provider level. Due to COVID-19 impacts, hybrid measures will be reported as either current year's (MY2019) or prior year's (MY2018) hybrid rates or current year's (MY2019) administrative-only rates, whichever was better. Data continues to be reviewed for completeness and accuracy and final results will be published next quarter on our eQARR webpages and our consumer guides data.

C. Quality Improvement

External Quality Review

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

During the 1st quarter of 2020, the Access Survey of Provider Availability plan calls were completed and the EQR completed data entry and analysis. A final report was prepared by the EQRO at the end of December and provided to the DOH. Due to priorities related to COVID-19 during the 3rd qtr., DOH requested the EQRO to pause any activities related to the Access & Availability Survey. DOH will send out the final reports of the Access and Availability Survey after the results of the High-Volume Ratio PCP survey are distributed. This will occur after the 4th qtr.

For the Member Services Survey, the EQRO completed the survey at the end of the 1st quarter and provided the DOH with a draft final report. In the 2nd qtr. the EQRO started Member Services re-survey calls, at the direction of the DOH. Due to COVID-19, many of the MCO's were working staggered and remote schedules, but the EQRO did reach some live voices during the re-survey calls.

A new High-Volume PCP Ratio Survey was initiated and completed in the 1st qtr. During the 2nd qtr. the EQRO sent the DOH the draft final reports for their review. At the DOH's request, the EQRO did not initiate the next High Volume PCP Ratio Survey, until the Access and Availability reports were finalized. Because of circumstances due to COVID-19, at the beginning of the 3rd quarter the NYS DOH requested that the EQRO pause any further activities in the administration of the High-Volume Ratio PCP Ratio. The EQRO resumed the survey activities, but during the 4th qtr., DOH is holding results until the Access & Availability reports are distributed.

IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). The PNDS collects network information from around 300 active networks in NYS. IPRO facilitated ongoing adjustments and fixes required for the PNDS rebuild and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion and maintenance. A new data dictionary (version 10) was released to the health plans. The changes for version 10 included addition of new specialty codes, more alignment of adequacy requirements across plan types and some system updates. The submission error display was updated to make it more user friendly for reviewing of errors.

Based on consumer feedback and recommendations DOH has made significant edits to the New York State Provider & Health Plan Look Up tool including adding a 'Search by Type of Health Plan' feature and limiting facility data for clearer results. The website surpassed 1 million users during the COVID-19 pandemic and consistently exceeds previous years' traffic by more than 50%.

The Panel data submission opened on 8/3/2020-8/31/2020 and yielded 5,909,896 rows of data.

Continuous efforts to work with health insurance plans to increase validation thresholds checks on data elements have shown successful with incorporating quarterly analytics to plans at risk of failing the newly updated requirements. Keeping a Standardized Operating Procedure (SOP) has reduced cycle and process times while reducing the amount of rework. This project is currently undergoing the lean improvement process to further identify efficiencies for end users.

In the 1st qtr. the EQR prepared a template for the MLTC PIP Interim Reports, and additionally sent an email to the MLTC plans to remind them of the January deadline for the Interim Reports. The MLTC PIP Interim reports for the 2019 PIPS were due to the EQRO

by January 31, 2020. All plans submitted their interim reports to the EQRO, and the EQRO initiated and completed review of one-third of the reports by the end of the 2nd qtr. The EQRO's review of the remainder of the Interim reports was completed in the 3rd qtr. At the end of the 3rd quarter it was determined that the MLTC PIP would be extended an additional year, until 12/31/21. The MLTC organizations were notified by the EQRO that the PIP would be extended. In the 4th qtr. the EQR conducted 2 group plan calls.

In the 1st qtr. the DOH asked the EQRO to provide a template for the 2016/17 MLTC PTR The EQRO worked on finalizing a revised template for the 2016/17 aggregated MLTC PTR, during the 2nd qtr. They made many revisions to the template at the DOH's request, and provided DOH with the draft template in the beginning of the 3rd qtr. The DOH decided to add 2018 data to the aggregated MLTC PTR. In the 4th qtr. the template was under DOH review and comment.

In the 1st qtr. the MLTC Satisfaction Survey was completed and the EQRO compiled data and prepared a draft final report of the survey results. During the 2nd qtr., the EQRO's technical writing team reviewed the draft report, and sent it on to the DOH for their review and comment. The EQRO was made DOH's changes to the report, during the 2nd qtr., and returned the revised report to the DOH before the beginning of the 3rd qtr. During the 3rd quarter, the EQRO made changes requested by DOH, to the draft final report of the MLTC Satisfaction Survey. During the 4th qtr. the final report was in the DOH review and approval process and the EQRO was waiting for any feedback.

In the 1st. qtr. the final report of the MLTC Encounter Data Validation Survey was prepared by the EQRO and was provided to the DOH in the 2nd quarter of 2020. The EQRO also completed an abstract review and finished a proposal of an Encounter Data Validation survey for dental and transportation services in the MLTC plans. Medical record requests for the MLTC Encounter Data validation survey were sent out to hospitals by the EQRO, and were provided to the DOH. At DOH's request, the EQRO paused any further medical record requests, due to COVID-19 priorities in the hospitals. For the 3rd quarter, the EQRO reviewed the responses for the mainstream MMC Encounter Data Validation survey. The EQRO also made changes to the proposal for the MLTC encounter data validation survey, with a focus on dental services. In the 4th qtr. the EQRO sent out record requests to the MLTC plans for their dental encounter records. Many MLTC plans responded that they had no dental records. The EQRO is following up with the plans, and may reach out to the dental vendor commonly used by many of the MLTC plans, for clarification.

The Adult CAHPS survey was completed in qtr. 1 of 2020. The EQRO prepared and cleaned survey data for review by the DOH. During qtr. 2, the subcontractor, DataStat, sent the final survey file to the DOH. Conference calls were conducted with EQRO, DataStat and the DOH, to discuss the survey findings. During the 3rd quarter the EQRO prepared the draft final copies of plan specific reports of the Adult CAHPS survey, for the DOH. DOH reviewed the draft copies and will finalize and distribute the reports to the plans. In the 4th qtr. the Adult CAHPS final reports were distributed and planning for the Child CAHPS survey began.

The Diabetes Self-Management Education (DSME) survey was completed in Q4 of the 2019. In Q1 of 2020, IPRO prepared the survey results and provided it to the NYSDOH. In qtr. 2 the EQRO prepared a final report of the findings of the Diabetes Self-Management Education (DSME) Non-CAHPS Survey. The report was submitted to the DOH for re view and comments. The DOH revised the report during qtr. 2. In the 3rd quarter, the DOH provided the EQRO with their changes to the final report of the survey. The EQRO conducted a conference call meeting with the DOH to discuss these changes. The final report was revised by the EQRO, per DOH comments, and the report was sent back to DOH for their review. In qtr. 4 the report remained in DOH review and approval process.

In the first quarter of 2020, the EQRO received the statistical analysis data for the HARP Non-CAHPS (Perceptions of Care) Survey, and built a report. IPRO provided the draft final report to OMH with the findings of the survey in the 2nd quarter of 2020. For the 3rd quarter, the EQRO received comments on the HARP Non-CAHPS Survey (Perceptions of Care) final report, from the NYS Office of Mental Health (OMH). OMH requested that the EQRO re-run the survey data and provide the new data file to OMH. At the end of the 3rd quarter, the EQRO was re-running the data file. The EQRO provided OMH with the final revisions to the report in the 4th qtr., and the report remained in OMH review.

Work was done by the EQRO on a new Focused Clinical Study (FCS), on MLTC Frailty, in the 1st qtr. This work included research and analysis on various Frailty indices. In the 2nd qtr. the EQRO prepared a draft final report of the FCS on MLTC Frailty. The EQRO provided the DOH with the draft report and incorporated any revisions requested by the DOH. At the end of the 2nd qtr., the draft final report was under review by the DOH. In the 3rd quarter the DOH provided the EQRO with their report comments, and the EQRO provided DOH with an edited and finalized version of the report. The report was sent through DOH OQPS review and approval process and was returned to the EQRO for revisions. The EQRO completed any work on the FCS in the 4th qtr., and the report remained in the DOH review and approval process.

In the 1st qtr. the DOH had a call with the EQRO to discuss the annual EQR Plan Technical Reports. In the 2nd qtr. the DOH provided the EQRO with the data to populate the reports and the EQRO began drafting the All Plan Summary Report for DOH review. During the 3rd quarter the EQRO prepared the DOH with a final version of the External Quality Review All Plan Summary Technical report – Reporting Year 2018. DOH submitted this report to CMS by the April 30th deadline. The EQRO provided a draft individual plan technical report for DOH review and approval. In the 4th qtr. the DOH was reviewing the draft individual plan technical report.

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

2017-18 HARP PIP

For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic was Inpatient Care Transitions. Final reports for the 2017-18

HARP PIP projects were received in August 2019 and were finalized and approved in October 2019. The PIP Compendium of Abstracts was drafted in July 2020 and is currently under review by NYSDOH. Once the Compendium is approved it will be available on the NYSDOH public website.

2017-18 Perinatal Care

For the 2017-2018 PIP for the MMC plans, the selected common topic was Perinatal Care. There were four priority focus areas addressed in this PIP: history of prior spontaneous preterm birth; unintended pregnancy suboptimal birth spacing; maternal smoking; and maternal depression. The PIP Final Reports were received in July 2019 and were finalized and reviewed. A PIP Compendium of Abstracts was prepared by IPRO and was reviewed by the NYSDOH and finalized in August 2020 and is currently under review by NYSDOH. Once the Compendium is approved it will be available on the NYSDOH public website.

2019-20 HIV-SNP PIP

The three HIV SNP Plans submitted their 2019-2020 PIP Proposals by December 21, 2018. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH in February 2019. One of the three HIV SNP's will participate in the HARP PIP topic. The other two HIV SNPs are each conducting separate PIP topic areas. Oversight calls were conducted in October 2019, February 2020 and June 2020. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report was submitted in January 2020. IPRO and NYSDOH reviewed and finalized the Interim Reports with the MCOs. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Due to the COVID-19 pandemic some of their PIP planned interventions have appropriately been delayed in order to address the immediate needs of the members during this health crisis. MCOs were requested to take the one year extension as an opportunity to review their planned interventions and make any modifications needed. They were informed of the dates for oversight calls in 2020 and the next Interim Report update due in February 2021.

2019-20 HARP PIP

The 2019-2020 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. The HARP PIP Proposals were due December 21, 2018. The submitted PIP Proposals were reviewed and finalized by IPRO, NYSDOH and partners (including OASAS and OMH). Oversight calls were conducted in October 2019, February 2020 and June 2020. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report was submitted in January 2020. IPRO and NYSDOH reviewed and finalized the Interim Reports with the MCOs. Webinars were conducted with all the MCOs on December 9, 2019, February 12, April 22 and June 29, 2020. The MCOs presented to IPRO, NYSDOH and the MCOs their progress on the PIP. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Due to the COVID-19 pandemic some of their PIP planned interventions have appropriately been delayed in order to address the immediate needs of the members during this health crisis. MCOs were requested to take the one year extension as an opportunity to review their

planned interventions and make any modifications needed. They were informed of the dates for oversight calls in 2020 and the next Interim Report update due in February 2021.

2019-2020 Medicaid KIDS Quality Agenda

The 2019-2020 Medicaid managed care (MMC) PIP topic is the KIDS Quality Agenda Performance Improvement Project. The overall goal of the PIP is to optimize the healthy development trajectory by decreasing risks for delayed/disordered development. The areas of focus for the PIP include screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children. The PIP Proposals were due in the first quarter of 2019. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH. Oversight calls were conducted in November 2019, March 2020 and July 2020. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report was submitted in January 2020. IPRO and NYSDOH reviewed and finalized the Interim Reports with the MCOs. In October 2019 the new updated "Guidelines for the Health Care Providers for the Prevention, Identification and Management of Lead Exposure in Children" along with a copy of the letter from Commissioner Zucker to Health Care Providers and additional resource materials was distributed to the MCOs. Plan-Specific Member Level Files for Lead Testing results data were sent to the plans quarterly beginning on March 29, 2019. Plan Specific Member Level Files for Hearing Screening data were distributed to plans monthly by NYSDOH beginning on May 29, 2019. Webinars were conducted with all the MCOs on January 27, May 6, May 28 and July 29, 2020. The MCOs presented to IPRO, NYSDOH and the MCOs their progress on the PIP. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Due to the COVID-19 pandemic some of their PIP planned interventions have appropriately been delayed in order to address the immediate needs of the members during this health crisis. MCOs were requested to take the one year extension as an opportunity to review their planned interventions and make any modifications needed. They were informed of the dates for oversight calls in 2020 and the next Interim Report update due in February 2021.

Breast Cancer Selective Contracting

Staff completed the Breast Cancer Selective Contracting process for contract year 2020-2021. This included: updating the computer programs used to extract and analyze inpatient and outpatient surgical data from the Statewide Planning and Research Cooperative System (SPARCS); identifying low-volume facilities for restriction; notifying restricted facilities of their status; conducting the appeals process; posting the list of restricted facilities to the NYS DOH public website; and, supplying the list of restricted facilities to eMedNY staff so that Medicaid fee-for-service payments can be appropriately restricted, as well as, sharing the list with Medicaid managed care health plans' Chief Executive Officers and Medical Directors.

In total, the annual review identified 227 facilities. Facility designations were as follows: 114 high-volume facilities, 24 low-volume access facilities, and 89 low-volume restricted facilities.

Staff also completed the summer review of breast cancer surgical volume data. Provisional volume designations for contract year 2021-2022 were shared with facilities' SPARCS coordinators in October 2020. Release of these data will give facilities ample time to identify and correct any discrepancies between facility-calculated volume and SPARCS reported volume.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 4 (7/1/2020-9/30/2020)
As of September 2020, there were 10,048 NCQA-recognized PCMH providers in New York State. Approximately 11.41% (1,146) are recognized under the 2014 set of standards. In PCMH 2014 standards, practices received a higher score or level if they demonstrated more elements of patient-centered care.

On April 1, 2017, NCQA released their 2017 recognition standards, eliminating the leveling structure and making recognition valid for one-year periods instead of the previous three-year period to measure performance more frequently. There are 8 providers and 4 practices recognized under the 2017 standards.

On April 1, 2018 the New York State Department of Health released a new recognition program called the New York State Patient-Centered Medical Home (NYS PCMH). NYS PCMH is based on the PCMH 2017 recognition but requires practices to achieve a higher number of criteria to achieve recognition, with emphasis placed on behavioral health, care management, population health, value-based payment arrangements, and health information technology capabilities. There are 8,894 providers and 2,343 practices recognized under NYS PCMH. Of the providers that became recognized in September 2020, 67 were new to the NYS PCMH program.

Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017-recognizerd providers. Current information on PCMH incentives in Medicaid can be found here: https://www.health.ny.gov/health_care/medicaid/program/update/medup-pa-pn.htm#patiented.

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of September 2020 are:

- 2014 level 2: $0 PMPM
- 2014 level 3: $6.00 PMPM
- 2017 recognition: $6.00 PMPM
- NYS PCMH recognition: $6.00 PMPM

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2020 but discussions around alignment of methods for shared savings models are still not finalized.

All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the NYSDOH website, available here: https://www.health.ny.gov/technology/nys_pcmh/.

Demonstration Year: 22 (4/1/2020-3/31/2021)
The number of NCQA-recognized providers in New York State has steadily increased throughout the year. In October 2019, there were 9,633 NCQA-recognized PCMH providers in New York State, this number grew to 10,048 by the end of September 2020. The number of NCQA-recognized PCMH practices in New York State also increased throughout the year, going from 2,617 in October 2019 to 2,738 in September 2020.

The first providers and practices achieved NYS PCMH recognition in July 2018. As of September 2020, 2,343 practices have achieved NYS PCMH recognition. From October 2019 to September 2020, the number of PCMH providers recognized under NYS PCMH standards went from 5,173 (53.70% of all PCMH recognized providers in NYS) to 8,894 (88.52%).

As of September 2020, incentive payments for 2014 level 2 standards remain discontinued and incentive payments for 2014 level 3, 2017 standards, and NYS PCMH standards are set at $6.00 PMPM.

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

Quarterly budget neutrality reporting is up to date and on schedule. The State continues to work with CMS in resolving issues with the reporting template and PMDA system and in eliminating delays in the utilization of the Budget Neutrality Reporting Tool for quarterly timely reporting.

The State is also awaiting a decision on two timely filing waivers submitted to correct reporting errors noted in previous quarterly reports:

- As detailed in STC X.10, the State identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the October 1, 2011 through March 31, 2016 period. The audit was completed over the summer of 2018. A final audit report was submitted to CMS on September 19, 2019 with CMS confirming in a subsequent discussion on October 10, 2019 that all corrective action requirements outlined in the STCs have been satisfied. The State has addressed all

audit findings, however, entry of corrected data for F-SHRP DY6 into MBES is pending approval of a timely filing waiver.

- The State has also requested a timely filing waiver to address an issue with reporting for DY18 Q1-4 and DY19 Q1 resulting from an error in the query language used to pull data for this time period which resulted in the exclusion of F-SHRP counties for these quarters. This error was not uncovered until all DY18 quarters were processed, allowing for comparisons to previous the full data years that had already been reported, and the source of the issue was not identified until DY19Q1 was already processed.

X. Other

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

NYS Compliance

The State sends the following files to CMS monthly:

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

The State is current in its submission of these files. Moreover, New York State has actively addressed the data quality issues related to the Top 23 Priority Issues (TPIs) identified by CMS and stands in the highest compliance category (Blue) as defined by CMS for 2020.
New York State is working closely with CMS and its analytics vendors to improve the data quality of its submissions.

The State has completed the resubmission of historical claim files for the period July 2015 through May 2020 per CMS's request.

The State is also working closely with CMS to address new T-MSIS reporting requirements in relation to the COVID-19 public health emergency.

B. 1115 Waiver Public Comment Days

With the implementation of the Medicaid Redesign Team in 2011, New York has prioritized transparency and public engagement as a key element of developing and implementing Medicaid policies. The public comments provided at these forums have been shared with the New York

teams working on these programs and has informed implementation activities. We will continue to consider these issues and engage stakeholders as part of our ongoing efforts.

On October 25, 2019, the Department of Health conducted a public forum held at Baruch College, 55 Lexington Ave (Corner of 24th Street & Lexington Ave), Room 14-220 (14th Floor), New York, NY 10010. A second public forum was held on October 30, 2019 at The Oncenter Carrier Theater, 421 Montgomery Street, Syracuse, NY 13202.

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

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

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

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Submitted via email: December 29, 2020
Uploaded to PMDA: December 29, 2020

Critical Incidents July - September 2019

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	9	0	0	0	9	0	0	0	0	8,137	0.11%
AgeWell NY	11	0	0	0	2	4	4	1	0	12,123	0.09%
Archcare Community Life	36	1	0	1	8	0	15	11	0	5,123	0.70%
Archcare PACE	21	0	0	0	1	0	9	11	0	837	2.51%
Catholic Health-LIFE	12	0	6	0	0	0	4	2	0	259	4.63%
Centerlight PACE	44	0	0	0	0	0	27	17	0	2688	1.64%
Centers Plan for Healthy Living	98	0	0	0	26	9	25	38	0	36,778	0.27%
Centers Plan for Healthy Living MAP	1	0	0	0	1	0	0	0	0	14	7.14%
Complete Senior Care	3	0	0	0	0	0	2	1	0	125	2.40%
Eddy SeniorCare	7	0	0	0	0	0	4	3	0	210	3.33%
Elant Choice (EverCare)	51	0	0	0	0	0	13	51	0	968	5.27%
Elderplan MAP	0	0	0	0	0	0	0	0	0	1573	0.00%
Elderserve	240	1	0	1	7	12	79	140	0	15,167	1.58%
Elderwood	5	0	0	0	0	0	3	2	0	882	0.57%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	7,227	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	12	0.00%
Extended	74	0	0	0	0	4	28	42	0	7076	1.05%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	955	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	138	0.00%
Fidelis Care at Home	0	0	0	0	0	0	0	0	0	23,664	0.00%
Fidelis MAP	0	0	0	0	0	0	0	0	0	80	0.00%
Hamaspik	16	0	0	0	1	2	9	4	0	2,402	0.67%
Healthfirst CompleteCare	132	0	0	0	4	0	27	101	0	26146	0.50%
HomeFirst, Inc. (Elderplan)	3	0	0	0	3	0	0	0	0	1573	0.19%
Icircle	0	0	0	0	0	0	0	0	0	4,189	0.00%
Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	739	0.00%

Independent Living Services of CNY (PACE CNY)	28	0	0	0	0	0	11	17	0	632	4.43%
Integra MLTC	0	0	0	0	0	0	0	0	0	22,377	0.00%
Kalos ErieNiagara DBA: First Choice Health	1	0	0	0	1	0	0	0	0	1,484	0.07%
MetroPlus	0	0	0	0	0	0	0	0	0	2,058	0.00%
Monefiore	2	0	0	0	0	1	0	2	0	1,757	0.11%
Prime	53	0	0	0	1	2	15	35	0	524	10.11%
Senior Health Partners	117	0	0	0	0	1	25	91	0	15,320	0.76%
Senior Network Health, LLC	9	0	0	0	0	0	6	3	0	589	1.53%
Senior Whole Health	2	0	0	0	1	1	0	2	0	15,105	0.01%
Senior Whole Health MAP	2	0	0	0	0	0	0	0	0	85	2.35%
Total Senior Care	5	0	0	0	0	0	0	5	0	124	4.03%
Village Care	303	0	0	0	36	0	73	194	0	12,051	2.51%
Village Care MAP	91	0	0	0	20	0	13	58	0	1599	5.69%
VNA Homecare Options (Nascentia Health Options)	111	0	0	2	0	4	40	65	0	7,953	1.40%
VNS Choice MAP TOTAL	26	0	0	0	0	0	5	21	0	2368	1.10%
VNS Choice MLTC	167	0	0	0	1	1	49	116	0	19,502	0.86%
total	1680	2	6	4	122	41	486	1033	0		

Managed Long Term Care Partial Capitation Plan Enrollment October 2019 - September 2020												
	Oct-19	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	8,209	8,248	8,267	8,266	8,251	8,159	8,068	7,956	7,751	7,606	7,139	6,951
AgeWell New York	12,227	12,348	12,429	12,526	12,694	12,773	12,873	12,784	12,579	12,534	11,942	11,983
ArchCare Community Life	5,109	5,096	5,033	5,005	4,972	4,951	4,924	4,890	4,804	4,752	4,501	4,496
Centers Plan for Healthy Living	37,385	37,985	38,703	39,183	39,762	40,467	41,047	41,477	41,774	42,006	41,739	42,189
Elant	986	1,003	1,020	1,022	1,056	1,068	1,068	1,067	1,099	1,117	1,107	1,104
Elderplan	14,911	15,114	15,379	15,502	15,563	15,638	15,715	15,834	15,610	15,389	14,293	14,258
Elderserve	15,260	15,336	15,422	15,455	15,491	15,537	15,631	15,676	15,547	15,511	15,077	15,115
Elderwood	919	935	971	962	981	985	977	1,003	985	988	806	837
Extended MLTC	6,967	6,956	6,952	6,948	6,983	6,994	6,986	6,972	6,880	6,788	6,640	6,587
Fallon Health Weinberg (TAIP)	959	968	971	992	1,001	1,001	1,016	1,023	1,011	1,001	880	892
Fidelis Care at Home	23,568	23,474	23,350	23,088	22,647	22,273	22,160	21,911	26,042	25,548	21,848	21,625
Hamaspik Choice	2,413	2,424	2,384	2,376	2,370	2,354	2,311	2,298	2,255	2,256	2,170	2,147
HealthPlus- Amerigroup	7,209	7,215	7,180	7,132	7,124	7,076	7,010	6,914	6,596	6,363	5,952	5,889
iCircle Services	4,305	4,425	4,517	4,660	4,728	4,803	4,863	4,861	4,860	4,867	3,995	4,061
Integra	23,211	23,985	25,131	26,069	26,914	27,885	28,626	29,430	29,977	30,626	31,288	32,694
Kalos Health- Erie Niagara	1,519	1,522	1,530	1,544	1,544	1,483	1,470	1,480	1,437	1,410	974	952
MetroPlus MLTC	2,078	2,077	2,072	2,076	2,088	2,084	2,081	2,080	2,026	1,978	1,652	1,634
Montefiore HMO	1,767	1,765	1,779	1,796	1,812	1,811	1,803	1,800	1,772	1,744	1,621	1,612
Prime Health Choice	545	548	550	555	572	578	579	592	587	586	574	581
Senior Health Partners	15,206	15,394	15,414	15,281	15,240	15,198	15,163	15,030	14,585	14,298	13,286	13,301
Senior Network Health	599	599	587	575	579	577	584	584	576	571	429	428
Senior Whole Health	15,047	14,969	14,883	14,734	14,443	14,183	14,029	14,065	13,901	13,712	13,239	13,125
United Healthcare	4	1	0	0	0	0	0	0	0	0	0	0
Village Care	12,168	12,271	12,389	12,542	12,609	12,709	12,841	13,025	13,015	12,985	12,887	12,851
VNA HomeCare Options	7,994	7,986	7,881	7,793	7,693	7,416	7,350	7,279	7,029	6,860	3,410	3,390
VNS Choice	19,692	19,970	20,154	20,264	20,458	20,556	20,798	21,158	21,066	20,936	19,859	20,253
WellCare	5,843	5,834	5,795	5,767	5,718	5,568	5,362	5,168	0	0	0	0
TOTAL	**246,100**	**248,448**	**250,743**	**252,113**	**253,293**	**254,127**	**255,335**	**256,357**	**253,764**	**252,432**	**237,308**	**238,955**
PACE & MAP Enrollment October 2019 - September 2020												
	Oct-19	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**
PACE	5,743	5,756	5,734	5,724	5,769	5,748	5,727	5,720	5,633	5,585	5,567	5,559
MAP	17,778	17,700	17,620	20,241	20,452	20,732	20,888	21,086	21,391	21,754	21,941	22,369