IPRO

Better healthcare, realized.

New York State Medicaid Managed Long-Term Care

2022 External Quality Review Annual Technical Report

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

April 2024

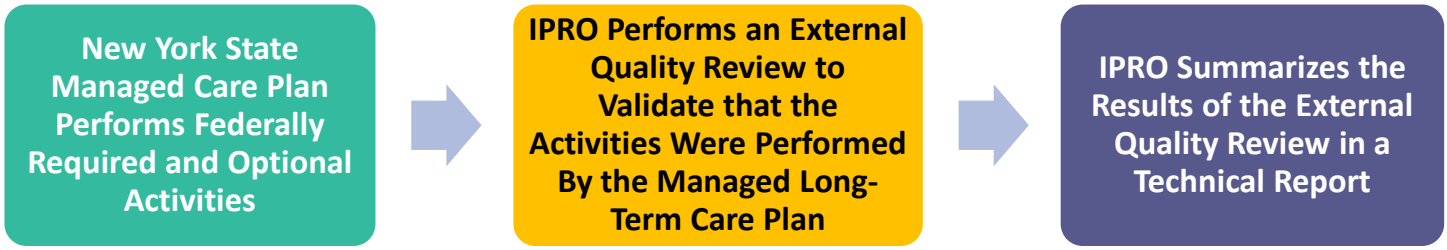
Prepared on behalf of:
The New York State Department of Health

Table of Contents

List of Tables

About This Report

The Balanced Budget Act of 1997 requires that state agencies contracting with Medicaid managed care and Children's Health Insurance Program plans provide for an annual, external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. The New York State Department of Health contracted with IPRO, an external quality review organization, to conduct the 2022 external quality review of the managed care plans that comprised New York's Medicaid managed care and Child Health Plus programs. Review results for one of New York's Medicaid products (Managed Long-Term Care) are summarized in this report, while results of New York's three other Medicaid products (Mainstream Medicaid, HIV Special Needs Plan, and Health and Recovery Plan) and Child Health Plus programs are summarized in a separate report.



This external quality review technical report focuses on three federally required activities (performance improvement projects, performance measures, and review of compliance with Medicaid and Children's Health Insurance Program standards) that were conducted between January 1, 2022, and December 31, 2022, or measurement year 2022.

Table 1: Managed Long-Term Care External Quality Review Activities Performed for 2022

What Did the Department of Health Do?	What Did the Managed Long-Term Care Plans Do?	What Did IPRO Do?
Required all managed care plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects.	Conducted performance improvement projects on social determinants of screenings and follow-up.	Evaluated how the managed care plans conducted performance improvement projects.
Required all managed care plans to collect and report certain health data. These data are called performance measures.	Collected and reported performance measure data to the Department of Health.	Reviewed data collection methods used by the managed care plans to calculate performance measures rates.
Required all managed care plans to comply with federal and state standards for Medicaid; and conducted an evaluation to determine managed care plan compliance with these standards.	Presented evidence of compliance with Medicaid standards to the Department of Health.	Reviewed the results of an evaluation of managed care plan compliance with Medicaid standards.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care and Children's Health Insurance Program plans provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan The Medicaid standards at Title 42 Code of Federal Regulations Section 438.350 External quality review and Child Health Insurance Program standards at Title 42 Code of Federal Regulations Section 457.1250 External quality review set forth the requirements for the annual external quality review of contracted managed care plans[1]. *(Hereafter, only Medicaid standards are referenced.)* States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care and Children's Health Insurance Program plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare & Medicaid Services.[2] Quality, as it pertains to an external quality review, is defined in *42 Code of Federal Regulations 438.320 Definitions* as "the degree to which a managed care plan, PIHP[3], PAHP[4], or PCCM[5] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

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

To comply with *42 Code of Federal Regulations Section 438.364 External quality review results (a)* through *(d)* and *42 Code of Federal Regulations 438.358 Activities related to external quality review*, the Department of Health has contracted with IPRO, an external quality review organization, to conduct the 2022 external quality review of the managed care plans that are part of New York's Managed Long-Term Care program.

2022 External Quality Review

This external quality review technical report focuses on three federally required activities (validation of performance improvement projects, validation of performance measures, and review of compliance with Medicaid and Children's Health Insurance Program standards) that were conducted for measurement year 2022. IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[6] published in February 2023. The external quality review activities and corresponding protocols are described in Table 2.

---

[1] Child Health Insurance Program standards at *Title* 42 *Code of Federal Regulations* 457.1250 cross-reference to the Medicaid managed care external quality review requirements at *Title* 42 *Code of Federal Regulations* 438.356.
[2] The Centers for Medicare & Medicaid Services website: https://www.cms.gov/.
[3] prepaid inpatient health plan.
[4] prepaid ambulatory health plan.
[5] primary care case management.
[6] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf.

Table 2: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed managed care plan performance improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Department of Health's methodology for calculating performance rates using data reported to the Uniform Assessment System for New York by New York's Independent Assessor Program and Managed Long-Term Care plans. The Uniform Assessment System for New York includes the Community Health Assessment which is a web-based tool to conduct assessments at enrollment and annually thereafter, or sooner if needed.
Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of evaluations performed by the Department of Health and the Centers for Medicare & Medicaid Services of Managed Long-Term Care plan compliance with Medicaid standards. Specifically, this review assessed compliance with *42 Code of Federal Regulations Part 438 Managed Care Subpart B 438.56, Subpart C 438.100 and 438.114, Subpart D, Subpart E 438.330, Partial Capitation Article V(F), Medicaid Advantage Plus Section 16.1-16.5, Program of All-Inclusive Care for the Elderly Article III. D, New York State Public Health Law*[7] *Article 44* and *Article 49*, and *New York State Official Compilation of Codes, Rules, and Regulations Part 98-Managed Care Organizations*.[8]

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

[7] New York State Legislature Website: http://public.leginfo.state.ny.us/navigate.cgi?NVMUO.
[8] New York State New York Codes, Rules, and Regulations Website: https://regs.health.ny.gov/volume-2-title-10/content/subpart-98-1-managed-care-organizations.

History of New York State's Managed Care Programs

The New York State Medicaid managed care program began in 1997 when New York State received approval from the Centers for Medicare & Medicaid Services to mandatorily enroll Medicaid members in a managed care program through a Section 1115 Demonstration Waiver.[9] Section 1115 of the Social Security Act allows for "demonstration projects" to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The New York State Section 1115 Demonstration Waiver project began with these goals:

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

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

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

Today, Child Health Plus offers free or low-cost health insurance to uninsured children from birth until their 19th birthday. To qualify, families must have incomes below 400% of the federal poverty level, be ineligible for Medicaid, and be a resident of New York State. There are no resource requirements and no immigration criteria. There are no deductibles, co-payments, or co-insurance, but families with incomes above 222% federal poverty level are required to pay a monthly premium. All Child Health Plus health services in New York State are provided through managed care plans. Application and renewal for Child Health Plus is through the New York State of Health Marketplace, where consumers are able to apply for and renew Child Health Plus coverage, as well as enroll in a health plan.

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

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

[9] Medicaid.gov About 1115 Demonstrations Website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

monitoring and ongoing quality improvement. The Department of Health updates the Medicaid and Child Health Plus quality strategy as needed, but no less than once every three years.

New York State's 2020–2022 Medicaid and Child Health Plus Quality Strategy[10] focuses on achieving measurable improvement and reducing health disparities through ten high-priority goals. Based on the Triple Aim framework, the state organized its goals by these aims: 1) improved population health; 2) improved quality of care; and 3) lower per-capita cost. New York State's Medicaid and Child Health Plus quality strategy aims and corresponding goals are:

- Triple Aim 1: Improved Population Health
  Goal 1: Improve maternal health
  Goal 2: Ensure a healthy start
  Goal 3: Promote effective and comprehensive prevention and management of chronic disease
  Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings
  Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder

- Triple Aim 2: Improved Quality of Care
  Goal 6: Improve quality of substance use disorder and opioid use disorder treatment
  Goal 7: Promote prevention with access to high-quality care
  Goal 8: Support members in their communities
  Goal 9: Improve patient safety

- Triple Aim 3: Lower Per-Capita Cost
  Goal 10: Pay for high-value care

The state has further identified 24 metrics to track progress towards the ten goals listed above. These metrics were selected from the New York State Quality Assurance Reporting Requirements measurement set, the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System and Behavioral Risk Factor Surveillance System, the National Survey on Drug Use and Health, 3M's Potentially Preventable Admissions, the Centers for Medicare & Medicaid Services' *Early and Periodic Screening, Diagnostic and Treatment Annual Participation Report,* and other New York State-specific measures. Table 3 presents a summary of the state's quality strategy measurement plan, including metric names, populations included in the calculation of the metrics, baseline data, and targets. Unless indicated otherwise, baseline measurements are from measurement year 2019 (January 1, 2019 through December 31, 2019), year 1 remeasurement rates are from measurement year 2020 (January 1, 2020 through December 31, 2020), year 2 remeasurement rates are from measurement year 2021 (January 1, 2021 through December 31, 2021), and year 3 remeasurement rates are from measurement year 2022 (January 1, 2022 through December 31, 2022).

[10] The New York State Medicaid/Child Health Plus Insurance Program Quality Strategy Website: https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-03-14_chplus_quality_strategy_final.pdf.

Table 3: New York State's Medicaid and Child Health Plus Quality Strategy Metrics and Performance Rates

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
Triple Aim 1: Improved Population Health						
Goal 1: Improve maternal health	Postpartum care (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan)	83%	80%	81.33%	82.44%	84%
	Maternal mortality rate per 100,000 live births[7] (All New York State)	18.9[1]	18.1[3]	19.3[4]	19.3[5]	16.0
Goal 2: Ensure a healthy start	Lead screening in children (Mainstream Medicaid, Child Health Plus)	89%	87%	81.18%	80.66%	90%
	Members receiving oral health services by a non-dentist provider (Mainstream Medicaid)	0.8%	1.25%	1.38%	1.18%	1.6%
Goal 3: Promote effective & comprehensive prevention and management of chronic disease	Comprehensive diabetes care – HbA1c testing (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan)	93%	86%	89.49%	Retired Measure	94%
	Asthma medication ratio, 5-18 years (Mainstream Medicaid, Child Health Plus)	66%	68%	65.47%	64.84%	67%
	Asthma medication ratio, 19-64 years (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)	55%	49%	49.59%	58.12%	56%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
	Controlling high blood pressure (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan)	67%	56%	64.82%	66.63%	68%
	Follow-up after emergency department visit for mental illness – 30 days (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)	72%	67%	66.53%	66.09%	73%
Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings	Depression screening and follow-up for adolescents and adults (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan)	Not Applicable	Not Applicable	New Measure	First Year Rate Not Publicly Reported	To Be Determined
Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder	High school students reporting current use of alcohol on at least one day during the past 30 days[7] (Subset of high school students in New York State)	26.4%	Non-Survey Year	20.0%	Non-Survey Year	23.6%
	High school students reporting binge drinking on at least one day during the past 30 days[7] (Subset of high school students in New York State)	12.7%	Non-Survey Year	10.2%	Non-Survey Year	10.8%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
	High school students reporting current use of marijuana on at least one day during the past 30 days[7] (Subset of high school students in New York State)	19.1%	Non-Survey Year	14.2%	Non-Survey Year	17.1%
	Adult alcohol binge drinking[7] (All New York State)	25.48%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	24.0%
	Adult use of marijuana[7] (All New York State)	10.05%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	9.14%
	Adult use of cocaine[7] (All New York State)	2.82%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	2.37%
	Adult use of heroin[7] (All New York State)	0.3%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	0.17%
	Adult use of illicit drug use other than marijuana[7] (All New York State)	3.42%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	2.94%
	Medicaid smoking prevalence[7] (Mainstream Medicaid, Fee-For-Service)	23%	22.9%	19.1%	17.5%	21.4%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
Triple Aim 2: Improved Quality of Care						
Goal 6: Improve Quality of Substance Use Disorder and Opioid Use Disorder Treatment	Initiation of pharmacotherapy upon new episode of opioid dependence (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)	37%	45%	42.68%	44.63%	38%
	Initiation of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)[6]	50%	50%	48.99%	New Specifications for Measure	51%
	Engagement of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)[6]	20%	20%	18.68%	New Specifications for Measure	21%
Goal 7: Promote Prevention with Access to High Quality Care	Mainstream Managed Care population impacted by patient-centered medical home sites with NCQA recognition of 2014 Level 3 and up, active sites (Mainstream Medicaid)	69%	72%	67%	66%	70%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
Goal 8: Support Members in Their Communities	Potentially avoidable hospitalizations for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection[7] (Managed Long-Term Care)	2.76	No data due to COVID-19	No data due to COVID-19	No data due to COVID-19	2.7
	Members who rated the helpfulness of the plan in assisting them and their family to manage their illnesses such as high blood pressure or diabetes as good or excellent (Managed Long-Term Care)	86%	Non-Survey Year	87.3%	Non-Survey Year	87%
Goal 9: Improve Patient Safety	Appropriate treatment for upper respiratory infections, 3 months-17 years (Mainstream Medicaid, Child Health Plus)	94%	94%	96.16%	95.17%	95%
	Appropriate treatment for upper respiratory infection, 18-64 Years (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)	72%	75%	81.18%	79.48%	73%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
Triple Aim 3: Lower Per Capita Cost						
Goal 10: Pay for High-Value Care	Potentially preventable admissions per 100,000 members[7] (Mainstream Medicaid)	1,153	847	916.84	886.71	1,124-1,181
	Potentially preventable admission expenditures/ Total inpatient expenditures[7] (Mainstream Medicaid)	9.97	8.29	8.55	9.17	7.47-12.47
	Potentially preventable admissions per 100,000 members[7] (Mainstream Medicaid, Fee-For-Service)	1,097	820	834.95	798.36	1,069-1,124
	Potentially preventable admission expenditures/ Total inpatient expenditures[7] (Mainstream Medicaid, Fee-for-Service)	10.33	8.95	9.07	9.80	7.83-12.83

[1] Baseline rate is from measurement year 2015-measurement year 2017.
[2] Baseline rate is from measurement year 2017-measurement year 2018.
[3] Year 1 Remeasurement rate is from measurement year 2016-measurement year 2018.
[4] Year 2 Remeasurement rate is from measurement year 2017-measurement year 2019.
[5] Year 3 Remeasurement rate is from measurement year 2018-measurement year 2020.
[6] Trending is not available for this measure. The 2022 technical specifications for this measure are different than the technical specifications used in prior years.
[7] A lower rate indicates better performance.

To achieve the overall objectives of the New York State managed care programs and to ensure New York Medicaid and Child Health Plus recipients have access to the highest quality of health care, New York State's 2020-2022 Medicaid and Child Health Plus Quality Strategy focuses on measurement and assessment, improvement, redesign, contract compliance and oversight, and enforcement. The state targets improvement efforts through several activities such as clinical focus studies, clinical and non-clinical performance improvement projects, quality incentives, the quality performance matrix, performance reports, quality improvement conferences and trainings, and plan technical assistance. Descriptions of interventions planned by the Department of Health to achieve the goals of its 2020-2022 Medicaid and Child Health Plus Quality Strategy are described below.

Triple Aim 1: Improved Population Health

Goal 1: Improve maternal health

- Conduct an administrative and medical record analysis of New York State Medicaid managed care and fee-for-service members who were diagnosed with maternal sepsis to inform strategies to reduce maternal mortality and morbidity. The analysis will evaluate the characteristics, identification, and management of sepsis associated with pregnancy, delivery, postpartum, and post-abortion obstetrical states. Results will be used to identify women at risk for maternal sepsis and modifiable factors associated with maternal sepsis morbidity and mortality.
- Launch a New York State birth equity improvement project, aimed at addressing bias, racism, and disparities impacting maternal health through a birthing-facility-based learning collaborative.
- Lead the New York State Perinatal Quality Collaborative to reduce pregnancy complications, improve maternal and neonatal outcomes, and reduce racial/ethnic and geographic disparities.
- Establish a perinatal data module to support access to perinatal outcome data through the state's All Payer Database.
- Prioritize the public health focus of the New York State regional perinatal system through adoption of updated regulations that strengthen the role of regional perinatal centers, increase focus on obstetrical care, and incorporate birthing centers and midwifery birth centers into the system.
- Increase the number of midwifery birth centers statewide as a first level of care for low-risk pregnancies.
- Update standards for Medicaid providers who provide maternity care.
- Evaluate potential strategies for expanding access to childbirth education classes for pregnant individuals.
- Support the expansion of perinatal telehealth access, with a focus on rural hospitals and health care providers.
- Implement the recommendations of the New York State Postpartum Workgroup.
- Ensure postpartum home visits are available to all individuals on Medicaid who agree to have them.
- Work with maternal/perinatal infant community health collaboratives to expand and enhance community health worker services to address key barriers that impact maternal outcomes.
- Support a perinatal mood, anxiety, and depression education campaign.

Goal 2: Ensure a healthy start

- Continue 2019–2021 Kids Quality Agenda performance improvement project that aims to increase blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.
- Continue to promote the use of fluoride varnish in the primary care setting.
- Develop tools and resources for fluoride varnish training at the local level through an Oral Health Workforce grant.
- Increase fluoride varnish application in the medical setting through public health detailing of pediatric and family medicine practitioners by local health departments.

Goal 3: Promote effective and comprehensive prevention and management of chronic disease

- Continue the National Diabetes Prevention Program as a covered benefit for New York State adult Medicaid members to address the increasing challenges of prediabetes and type 2 diabetes.
- Proceed with the integration of primary care and behavioral health services through a variety of mechanisms.
- Continue interventions of the New York State Asthma Control Program:
  - Provide clinical and quality improvement resources and training to clinical sites to support the delivery of guideline-based medical care, including working with health systems to develop and implement asthma templates into their electronic health record systems to increase the meaningful use of health information technology.
  - Engage home nursing agencies and community-based organizations delivering home-based asthma services to provide training and resources to ensure in-home asthma services include multi-component approaches to asthma trigger reduction and self-management education for high-risk patients.
  - Build cross-sector linkages between health, housing, and energy to advance New York's "health across all policies" approach and integrate related initiatives into New York's value-based payment framework, in partnership with managed care plans, to ensure sustainability.
  - Promote evidence-based approaches to delivery of asthma-self management education across providers and settings (clinical, home, school, or community).
  - Drive collaborations across settings (home, school, community, and clinical) to build bi-directional communication and referral systems structured to support care coordination for people with asthma.
  - Partner with stakeholders to facilitate and promote environmental policies designed to support asthma control (e.g., smoke-free school grounds, anti-idling, and clean diesel policies), regionally and statewide.
- Continue partnership with New York State Primary Care Association and Community Health Center Association of New York State to:
  - Support federally qualified health centers in monitoring and tracking patient- and population-level clinical quality measures for hypertension prevalence, hypertension control, and undiagnosed hypertension.
  - Support providers in the use of patient- and population-level hypertension registries that are stratified by age, gender, race, and ethnicity.
  - Support practices in implementing team-based approaches to care using patient hypertension registries and electronic pre-visit planning tools.
  - Support federally qualified health centers in referring patients to home blood pressure monitoring with provider follow-up.
  - Support federally qualified health centers in implementing bi-directional referrals to community-based programs that support patients in their chronic disease self-management.

Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings

- New York State will be supporting the Zero Suicide model led by the Suicide Prevention Office at the Office of Mental Health. The Zero Suicide model approach calls for:
  - A fundamental commitment from health system leadership to reduce suicide attempts and deaths among those receiving care.
  - Systematic screening and assessment for the identification of those at-risk.
  - Delivery of evidence-based interventions by a competent and caring workforce.
  - Monitoring of those at risk between care episodes, especially care transitions.
  - Data-driven quality improvement to track and measure progress.
- Major demonstration projects are underway in Article 31 licensed mental health clinics, inpatient psychiatric units, substance use disorder settings, Comprehensive Psychiatric Emergency Programs, medical emergency departments, and primary care.

Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder

- Provide a comprehensive smoking cessation benefit for all Medicaid enrollees without cost sharing, prior authorization requirements, or limits on quit attempts. Enrollees are allowed concurrent use of products (two or more medications at once). Medicaid also pays for over-the-counter nicotine patches, gum, and lozenges (with a prescription from a provider).
- Continue providing access to the New York State Smokers' Quitline. The New York State Smokers' Quitline serves as a clinician treatment extender in New York's population-level, evidence-based approach to cessation, which focuses on health system changes to increase the delivery of tobacco dependence treatment, especially for subpopulations with high smoking prevalence, including Medicaid enrollees. The free and confidential Smokers' Quitline provides resources and technical assistance to assist Medicaid enrollees and other disparate populations in accessing and using cost-effective cessation benefits.
- Implementation of evidence-based, strategic, culturally appropriate, and high-impact paid media campaigns targeted at tobacco-related disparate populations to prevent initiation, increase cessation, increase awareness and use of Medicaid tobacco cessation benefits and the Smokers' Quitline, and prevent tobacco use relapse.
- Prevention of alcohol and substance use, misuse, and disorder through the Strategic Prevention Framework which includes a five-step, data-driven planning process designed to guide state and local communities in the selection, implementation, and evaluation of effective, culturally responsive, and sustainable prevention activities. Interventions included are:
    - Environmental change strategies
        - Policies (e.g., alcohol advertising restrictions, social host liability laws)
        - Enforcement (e.g., party patrols, compliance checks, sobriety checkpoints)
        - Media (e.g., social marketing campaign, media advocacy, social norms campaign)
    - Community-based substance use prevention coalitions
    - Family-focused prevention programming (e.g., Strengthening Families, Triple P – Positive Parenting Program®)
    - School-based prevention curricula
        - Universal (e.g., Too Good for Drugs, PAX Good Behavior Game®, Guiding Good Choices®, Positive Action®, LifeSkills® Training, Second Step®)
        - Selective/Indicated (e.g., Teen Intervene, PreVenture)
- New York State supports many strategies to address the opioid crisis and reduce opioid use such as:
    - Creation of policies
    - Provider and member education
    - Requirement of a written opioid treatment plan
    - Encourage the use of non-opioid alternatives
    - Increased access to drugs used for substance use disorder treatment
    - Participation in the Centers for Disease Control and Prevention's Prescription Drug Overdose Prevention initiative
    - Opioid use disorder/substance use disorder screening in primary care practices through the Delivery System Reform Incentive Payment program
    - Mandatory prescriber education program

Triple Aim 2: Improved Quality of Care

Goal 6: Improve quality of substance use disorder and opioid use disorder treatment

- Initiatives focused on improving treatment access to high-quality, evidence-based treatment for opioid use disorder and other substance use disorders. These include learning collaboratives for prescribing professionals to encourage increased access to buprenorphine-waivered professionals across the state; regulatory changes that require medication for opioid use disorder in all Office of Addiction Services and Supports-certified settings; and peers to provide linkage between levels of care and to connect people directly to care from emergency rooms or high-intensity care.
- Expansion of take-home methadone dosing program. Providing weekly, bi-monthly, or monthly take-home doses to patients who are stable will allow them to receive care in a more person-centered way, which should foster recovery and increase treatment retention.

Goal 7: Promote prevention with access to high-quality care

- Use of patient-centered medical homes to support the state's goal of improving primary care and promoting the Triple Aim: improving health, lowering costs, and improving patients' experience of care.
- Maximize workforce distribution by committing to consistent funding for Doctors Across New York. This will help to address workforce shortages with an annual cycle and predictable timeline for the application process and increase student exposure to rural and non-hospital settings through support of community rural training sites.
- Creation of a provider wellness survey that will seek to both establish baseline levels of burnout among New York State providers and uncover how the COVID-19 pandemic has affected providers' self-reported stress, burnout, and job satisfaction. Additionally, the survey will gauge the extent to which meeting regulatory reporting requirements for clinicians increases clinician burden and stress. Data will be shared between the Department of Health's Office of Quality and Patient Safety, the New York Chapter of American College of Physicians, and the Center for Health Workforce Studies.
- Promoting the use of community health workers to increase knowledge about the enrollee services and improve utilization among health care providers and agencies.
- Perform network adequacy analyses to ensure that managed care plans operating in New York State have an adequate number and variety of health care providers in their networks to provide appropriate access to care for their enrollees, which includes being geographically accessible (meeting time/distance standards based on geographic location), being accessible for the disabled, and promoting and ensuring the delivery of services in a culturally competent manner.
- New York State Medicaid and Child Health Plus cover services delivered by telehealth.
- The Department of Health requires plans to participate in collaborative studies with a common theme. Examples of common-themed performance improvement projects include *Perinatal Care* and *The Kids Quality Agenda Performance Improvement Project* for Mainstream Medicaid managed care plans; Inpatient Care Transitions and Care Transitions after Emergency Department and Inpatient Admissions for Health and Recovery Plans; and Transitions of Care and Emergency Department/Hospitalization Reduction for managed long-term care plans.
- Focused clinical studies, conducted by the external quality review organization, usually involve medical record review, measure development, surveys, and/or focus groups. Managed care plans are typically required to participate in one clinical focus study a year. Studies are often population specific (Medicaid managed care/HIV Special Needs Plan, Managed Long-Term Care, Health and Recovery Plan). Upon completion, the external quality review organization provides recommendations for improvement to the Department of Health, plans, and providers. Past studies have addressed frailty indices, the provision of advanced directives, functional assessment of inter-rater reliability, validation of vital statistics reporting, use of developmental screening tools, care transitions, and provision of prenatal care.

Goal 8: Support members in their communities

- Increase access to palliative care programs and hospice for persons with serious illnesses and life-threatening conditions to help ensure care and to understand, address, and meet end-of-life planning needs prior to decisions to seek further aggressive care.
- Use of the Integrated Palliative Care Outcomes Scale to measure access to palliative care services for patients most in need.
- Home- and community-based services are designed to allow enrollees to participate in a vast array of habilitative services. They are based on the idea that state services, programs, and activities should be administered in the most integrated and least restrictive setting appropriate to a person's needs. Home- and community-based services include managed long-term care services and supports, care coordination, skill building, family and caregiver support services, crisis and planned respite, prevocational services, supported employment services, community advocacy and support, youth support and training, non-medical transportation, habilitation, adaptive and assistive equipment, accessibility modifications, and palliative care.
- Nursing home transition and diversion waiver includes the following home- and community-based services: assistive technology, community integration counseling, community transitional services, congregate and home delivered meals, environmental modifications services, home- and community-support services, home visits by medical personnel, independent living skills training, moving assistance, nutritional counseling/educational services, peer mentoring, positive behavioral interventions and supports, respiratory therapy, respite services, structured day program services, and wellness counseling service.
- Community First Choice Option Waiver program is being phased in and includes the following home- and community-based services: assistive technology; activities of daily living and instrumental activities of daily living skill acquisition, maintenance, and enhancement; community transitional services; moving assistance; environmental modifications; vehicle modifications; and non-emergency transportation.
- Children's Home- and Community-Based Services program consolidates multiple 1915(c) children's waiver programs from different agencies, including:
    - The Department of Health's Care at Home Waiver for children with physical disabilities
    - The Office of Mental Health's Waiver for Children and Adolescents with Serious Emotional Disturbance
    - The Office for People with Developmental Disabilities' Care at Home Waiver
    - The Office of Children and Family Services' Bridges to Health Serious Emotional Disturbance Waiver, Bridges to Health Developmental Disability Waiver, and Bridges to Health Medically Fragile Waiver

Goal 9: Improve patient safety

- Improve appropriate use of antibiotics in outpatient healthcare settings to combat antibiotic resistance. Improvement in outpatient settings is done through targeted outreach to healthcare providers, development of clinician resources to support appropriate use of antibiotics, presentation of the data to clinicians to demonstrate the need for improvement, and the development of educational materials for patients. Additionally, collaborative efforts with stakeholders have helped promote the goal to reduce inappropriate antibiotic use.
- Continue to analyze Medicaid claims and pharmacy data, including a separate analysis of antibiotic prescribing for acute upper respiratory infection in pediatric and adult populations. Prescribing rates over time for each population by county of healthcare visit, in both tabular and map formats, have been made publicly available on the Health Data NY website. Data are prepared and presented by county to provide local data for local action. Data are shared through broad public health messaging and direct presentation upon request of stakeholders.
- Require acute care hospitals in New York State that provide care to patients with sepsis to develop and implement evidence-informed sepsis protocols which describe their approach to both early recognition and treatment of sepsis patients. In addition, hospitals were required to report to the Department of Health sufficient clinical data to calculate each hospital's performance on key measures of early treatment and

protocol use. Each hospital submits clinical information on each patient with severe sepsis and or septic shock to allow the Department of Health to develop a methodology to evaluate risk-adjusted mortality rates for each hospital. Risk adjustment permits comparison of hospital performance and takes into consideration the different mix of demographic and comorbidity attributes, including sepsis severity, of patients cared for within each hospital.

- The Medicaid Breast Cancer Selective Contracting policy was implemented in 2009 and mandates that Medicaid enrollees receive breast cancer surgery, i.e., mastectomy and lumpectomy procedures associated with a primary diagnosis of breast cancer, at high-volume hospital and ambulatory surgery centers. Research conducted by the Department of Health demonstrated improved 5-year survival for patients receiving breast cancer surgery at high-volume facilities.

Triple Aim 3: Lower Per-Capita Cost

Goal 10: Pay for high-value care

- Implement Medicaid reform and the move to value-based payments. This transformation promoted community-level collaboration and sought to reduce avoidable hospital use by 25% over the 5–year demonstration period, while financially stabilizing the state's safety-net providers. In just a few years, New York State has significantly moved its Medicaid program from almost exclusively fee-for-service to primarily value-based payment strategies.
- Continue to require certain value-based payment arrangements to include social determinants of health interventions and contractual agreements with one or more community-based organizations. New York State was the first state in the nation to require this. Every value-based payment risk arrangement (56% of Medicaid managed care expenditure) has a defined social determinants of health intervention and includes community-based-human and -social-services organizations.
- Continue to use the core measure set strategy implemented in 2018 which identifies the highest priorities for quality measurement and improvement and provides alignment with other national measurement sets such as the Merit-based Incentive Payment System.
- Promote data sharing via the Statewide Health Information Network for New York. The Statewide Health Information Network for New York "information highway" allows clinicians and consumers to make timely, fact-based decisions that can reduce medical errors, reduce redundant testing, and improve care coordination and quality. The successful implementation of the Statewide Health Information Network for New York is one of the drivers improving health care quality, reducing costs, and improving outcomes for all New Yorkers. Additionally, the Statewide Health Information Network for New York has been leveraged during the COVID-19 pandemic to support disease surveillance activities and assess hospital capacity. Work in this area continues, and the Statewide Health Information Network for New York will become an important component in all Department of Health emergency preparedness initiatives.
- Reduce avoidable hospital use by 25% over 5 years through New York State's Delivery System Reform Incentive Payment program. The Delivery System Reform Incentive Payment program ended on March 31, 2020.

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

The New York State Medicaid and Child Health Plus Quality Strategy for 2020-2022 generally aligns with the requirements of *42 Code of Federal Regulations 438.340 Managed Care State Quality Strategy*. It serves as a guiding framework for managed care plans, aiming to enhance the quality, timeliness, and accessibility of care. Clearly defined goals are supported by well-designed interventions, incorporating methods to measure and monitor progress through external quality review activities.

The strategy encompasses various quality improvement activities to establish an innovative, well-coordinated care system addressing both medical and non-medical determinants of health. These activities include performance improvement projects, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

From the baseline period (measurement year 2020) to Year 3 (measurement year 2022), statewide performance related to five goals either met or exceeded targets. This success was observed in areas such as asthma medication management in adults, smoking prevalence, pharmacotherapy treatment for substance abuse, appropriate treatment for upper respiratory infections in children and adults, and potentially preventable admissions and cost. Notably, increased access to oral health services in alternative settings was also demonstrated.

Despite positive outcomes, opportunities for enhancing health outcomes exist statewide. As evidenced by the performance in measurement year 2022, continued attention to population health and quality of care is warranted.

Moreover, there are opportunities to strengthen the effectiveness of the quality strategy. The Department of Health faces challenges in trending its performance from baseline for twelve quality strategy metrics due to data collection limitations. These limitations include the absence of data collection during the COVID-19 public health emergency, unavailability of data at the time of report production, measurement year 2022 not being a survey year, suppression of first-year measures from public reporting, and measure retirement.

Recommendations to the New York State Department of Health

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

- The Department of Health should consider extending the quality strategy target date for improvement beyond 2022 to allow itself more time to collect sufficient data for all metrics; and as data becomes available for newer metrics, the Department of Health should update the quality strategy to include baseline data and targets where applicable. If the Department of Health remains unable to collect data for certain metrics, the Department of Health should consider the use of alternative metrics.
- To increase the transparency and overall understanding of state-led compliance review activities, the Department of Health should consider revising related policies and procedures, and technical methods of data collection and analysis.
- Although quality rating protocols have not yet been issued by the Centers for Medicare & Medicaid Services, the Department of Health should consider including the results of its *Consumer Guide Star Rating* as a component of the annual external quality review report.

Medicaid Managed Long-Term Care Plan Profiles

There are three types of Medicaid Managed Long-Term Care plans: Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly. In 2022, there were 12 approved Medicaid Advantage Plus plans; 25 Partial Capitation plans; and 9 Program of All-Inclusive Care for the Elderly plans. Descriptions of the Managed-Long Term Care plan types are in Table 4.

Table 4: Managed Long-Term Care Plan Types

Managed Long-Term Care Plan Types
Medicaid Advantage Plus
Medicaid Advantage Plus plans must be certified by the Department of Health as a Managed Long-Term Care plan and by the Centers for Medicare & Medicaid Services as a Medicare Advantage plan. Medicaid Advantage Plus plans receive capitation payments from both Medicaid and Medicare. The Medicaid benefit package includes long-term care services, and the Medicare benefit package includes ambulatory care and inpatient services.
Partial Capitation
Managed Long-Term Care Partial Capitation is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or day care, are provided through Managed Long-Term Care plans that are approved by the Department of Health. Ambulatory care and inpatient services are paid by Medicare if the member is dually eligible for both Medicare and Medicaid, or by Medicaid if the member is not Medicare eligible. Medicaid capitation payments are provided to Partial Capitation plans to cover the costs of long-term care and selected ancillary services. Dual eligible individuals (having both Medicare and Medicaid), who are age 21 and older and who are assessed as needing community based long term care services for more than 120 days must enroll in Managed Long-Term Care in order to receive those services. The following may voluntarily enroll in Managed Long-Term Care: a. dual eligible individuals, age 18–20, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days; and b. non–dual eligible individuals, age 18 and older, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days.
Program of All-Inclusive Care for the Elderly
The Program of All-Inclusive Care for the Elderly provides a comprehensive system of health care services for members 55 years of age and older, who are otherwise eligible for nursing home admission. Both Medicaid and Medicare pay for Program of All-Inclusive for the Elderly services on a capitated basis. Under this program, members are required to use Program of All-Inclusive Care for the Elderly physicians. An interdisciplinary team develops a care plan and provides ongoing care management. This type of Managed Long-Term Care plan is responsible for directly providing or arranging all primary, inpatient hospital, and long-term care services needed by the member. The type of managed care plan is approved by both the Centers for Medicare & Medicaid Services.

Table 5 displays enrollment data for each Managed Long-Term Care plan. For each managed care plan type, the table displays the formal and abbreviated names of the managed care plan, and the total Medicaid enrollment as of December 2022.

Table 5: Managed Long-Term Care Profiles

Managed Long-Term Care Plan	Enrollment as of 12/2022[1]
Medicaid Advantage Plus	**35,061**
AgeWell New York Advantage Plus (AgeWell)	108
Centers Plan for Medicaid Advantage Plus (Centers Plan)	1,250
Elderplan, Inc. MAP (Elderplan)	3,131
Empire Blue Cross Blue Shield HealthPlus Duals Plus (Empire BCBS HealthPlus)[2]	206
Fidelis Medicaid Advantage Plus (Fidelis Care)	619
Hamaspik Inc. (Hamaspik)	586
MetroPlus Ultracare (MetroPlus)	41
MHI Healthfirst CompleteCare (MHI Healthfirst)	23,265
RiverSpring MAP (RiverSpring)	152
Senior Whole Health of New York MAP (Senior Whole Health)	138
VillageCareMAX Medicare Total Advantage (VillageCare)	2,577
VNS Health Total (VNS Health)	2,988
Partial Capitation	**256,557**
Aetna Better Health (Aetna)	5,550
AgeWell New York (AgeWell)[3]	No Enrollment
ArchCare Community Life (ArchCare)	5,381
Centers Plan for Healthy Living (Centers Plan)	48,662
Elderwood Health Plan (Elderwood)	1,093
Empire Blue Cross Blue Shield HealthPlus MLTC (Empire BCBS HealthPlus)	50,128
EverCare Choice (EverCare)	865
Extended MLTC, LLC (Extended MLTC)	5,657
Fallon Health Weinberg-MLTC (Fallon Health)	834
Fidelis Care at Home (Fidelis Care)	17,239
Hamaspik Choice, Inc. (Hamaspik)	1,953
HomeFirst, a product of Elderplan, Inc. (Elderplan)	16,781
iCircle Care (iCircle)	3,497
Integra MLTC, Inc. (Integra)[4]	No Enrollment
Kalos Health	543
MetroPlus MLTC (MetroPlus)	1,331
Montefiore Diamond Care (Montefiore)	1,370
Nascentia Health (Nascentia)	3,683
Prime Health Choice, LLC (Prime Health)	574
RiverSpring at Home (RiverSpring)	15,950
Senior Health Partners a Healthfirst Company (Senior Health Partners)	9,263
Senior Network Health, LLC (Senior Network Health)	331
Senior Whole Health of New York MLTC (Senior Whole Health)	26,110
VillageCareMAX (VillageCare)	16,450
VNS Health MLTC (VNS Health)	23,312

Managed Long-Term Care Plan	Enrollment as of 12/2022[1]
Program of All-Inclusive Care for the Elderly	8,408
ArchCare Senior Life (ArchCare)	670
Catholic Health-LIFE (Catholic Health)	247
CenterLight Healthcare PACE (CenterLight)	5,523
Complete Senior Care	125
Eddy SeniorCare	317
Fallon Health Weinberg-PACE (Fallon Health)	137
Independent Living for Seniors dba ElderONE (ElderONE)	734
PACE CNY	523
Total Senior Care, Inc. (Total Senior Care)	132

[1] Data Sources: New York State Department of Health Managed Long-Term Care Plan Directory, Revised October 2023. Website: https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm; and New York State Department of Health Medicaid Managed Care Enrollment Report, December 2022. Website: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

[2] Integra Synergy Medicare Advantage Plus (not shown) was acquired by Empire Blue Cross Blue Shield HealthPlus Duals Plus acquired on December 1, 2022. Integra Synergy Medicare Advantage Plus had no enrollment during 2022 for the Medicaid Advantage Plus program.

[3] AgeWell New York Partial Capitation Plan was acquired by Senior Whole Health of New York MLTC Partial Capitation Plan on October 1, 2022.

[4] Integra MLTC, Inc. Partial Capitation Plan was acquired by Empire Blue Cross Blue Shield HealthPlus MLTC Partial Capitation Plan on December 1, 2022.

External Quality Review Activity 1. Validation of Performance Improvement Projects

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards

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

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

In 2022, the Managed Long-Term Care performance improvement project topic was Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership.

2022 Performance Improvement Projects Summary

Validation Process

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

Validation Results

- All performance improvement projects passed validation.

Performance Improvement Project Results

- By the end of 2022, all Managed Long-Term Care plans had a standalone social determinants of health assessment tool in place.

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

Technical Summary – Validation of Performance Improvement Projects

Objectives

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

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

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

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

While interventions are managed care plan-specific, the performance improvement project focus area and performance indicators are consistent across the Managed Long-Term Care plans. The *Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership* project aims to increase managed care plan screening and follow-up related to social determinants of health among the Managed Long-Term Care population. Descriptions of the five required performance indicators are in Table 6.

Table 6: Required Performance Improvement Project Indicators, 2022-2023

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

Technical Methods for Data Collection and Analysis

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

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the managed care plan's enrollment and generalizable to the managed care plan's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the performance improvement project.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.

8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the managed care plan achieved sustained improvement.

Following review of the listed elements, findings were assessed to determine if they should be accepted as valid and reliable. The element was then determined to be "met" or "not met." While elements 1-8 are reviewed each year that the performance improvement project is in progress, elements 9 and 10 are included in the review the year that the performance improvement project concludes. IPRO did not review elements 9 and 10 as part of the validation activity for measurement year 2022 as the performance improvement projects continued into measurement year 2023.

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

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

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

Description of Data Received

For the 2022 external quality review, IPRO reviewed Managed Long-Term Care plan performance improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline and interim), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of each Managed Long-Term Care plan's performance improvement project methodology revealed there were no validation findings indicating that the credibility of the performance improvement project results was at risk. Summaries of the validation assessments are in Table 7 for Medicaid Advantage Plus, Table 8 for Partial Capitation Plans, and Table 9 for Program of All-Inclusive Care for the Elderly Plans. Performance indicator rates are in Table 10, Table 11, and Table 12.

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

Table 7: Medicaid Advantage Plus Performance Improvement Project Validation Findings, Measurement Year 2022

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

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

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

Table 8: Partial Capitation Performance Improvement Project Validation Findings, Measurement Year 2022

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

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

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

Table 9: Program of All-Inclusive Care for the Elderly Performance Improvement Project Validation Findings, Measurement Year 2022

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

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

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

Table 10: Medicaid Advantage Plus Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2022

Medicaid Advantage Plus Performance Improvement Project Indicator Rates					
Medicaid Advantage Plus	Percentage of New Enrollees with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Continuously Enrolled Members with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Care Manager Contacts Where a Social Determinants of Health Screen is Conducted	Percentage of Members with a Positive Social Determinants of Health Assessment	Percentage of Members with a Positive Social Determinants of Health Assessment Who Have Documented Interventions to Address Need(s)
AgeWell	10.00%	32.06%	27.14%	2.60%	28.57%
Centers Plan	78.54%	95.93%	52.70%	6.82%	88.37%
Elderplan	93.65%	100.00%	98.50%	10.76%	72.50%
Empire BCBS HealthPlus	36.56%	75.38%	97.38%	22.82%	75.00%
Fidelis Care	47.87%	82.64%	76.68%	17.58%	90.63%
Hamaspik	18.95%	Not Available	1.61%	72.22%	100.00%
MetroPlus	13.64%	95.00%	7.01%	0.00%	0.00%
MHI Healthfirst	26.25%	83.09%	11.84%	10.02%	74.23%
RiverSpring	38.52%	37.40%	8.82%	8.60%	44.44%
Senior Whole Health	0.00%	84.90%	20.30%	6.20%	87.50%
VillageCare	89.13%	12.63%	31.74%	34.82%	9.60%
VNS Health	21.90%	72.18%	7.80%	9.67%	56.50%

Table 11: Partial Capitation Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2022

Partial Capitation Performance Improvement Project Indicator Rates					
Partial Capitation Plan	Percentage of New Enrollees with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Continuously Enrolled Members with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Care Manager Contacts Where a Social Determinants of Health Screen is Conducted	Percentage of Members with a Positive Social Determinants of Health Assessment	Percentage of Members with a Positive Social Determinants of Health Assessment Who Have Documented Interventions to Address Need(s)
Aetna	65.90%	8.09%	0.01%	73.04%	89.39%
AgeWell	57.47%	65.18%	64.93%	3.20%	33.18%
ArchCare	45.45%	83.04%	53.47%	13.86%	64.89%
Centers Plan	94.36%	96.84%	50.60%	6.71%	83.34%
Elderplan	98.27%	100.00%	99.45%	8.97%	62.29%
Elderwood	81.04%	83.17%	12.14%	32.42%	30.77%
Empire BCBS HealthPlus	50.78%	53.14%	57.33%	7.12%	73.82%
EverCare	66.45%	98.35%	80.57%	13.24%	54.70%
Extended MLTC	92.00%	94.50%	47.82%	4.56%	100.00%
Fallon Health	100.00%	97.70%	99.63%	50.26%	58.22%
Fidelis Care	58.39%	74.54%	84.20%	18.88%	77.68%
Hamaspik	26.67%	1.17%	1.03%	25.00%	100.00%
iCircle	59.94%	86.50%	24.80%	36.45%	100.00%
Integra	98.83%	78.32%	78.90%	4.72%	38.18%
Kalos Health	0.00%	0.21%	0.37%	100.00%	100.00%
MetroPlus	45.67%	63.03%	5.28%	32.93%	96.71%
Montefiore	90.43%	92.72%	15.23%	2.53%	86.67%
Nascentia	41.64%	26.05%	58.48%	72.02%	32.91%
Prime Health	87.69%	92.73%	90.00%	64.81%	94.05%
RiverSpring	22.42%	24.49%	1.79%	3.15%	54.03%
Senior Health Partners	45.77%	91.79%	13.54%	11.40%	46.49%
Senior Network Health	81.82%	48.32%	5.41%	32.95%	8.62%
Senior Whole Health	5.48%	21.13%	18.39%	2.20%	20.38%
VillageCare	89.04%	21.85%	13.00%	40.98%	26.81%
VNS Health	39.12%	79.85%	12.76%	6.39%	45.62%

Table 12: Program of All-Inclusive Care for the Elderly Performance Improvement Project Social Determinants of Health Rates, Measurement Year 2022

Program of All-Inclusive for the Elderly Performance Improvement Project Indicator Rates					
Program of All-Inclusive Care for the Elderly Plan	Percentage of New Enrollees with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Continuously Enrolled Members with a Completed Stand-Alone Social Determinants of Health Assessment	Percentage of Care Manager Contacts Where a Social Determinants of Health Screen is Conducted	Percentage of Members with a Positive Social Determinants of Health Assessment	Percentage of Members with a Positive Social Determinants of Health Assessment Who Have Documented Interventions to Address Need(s)
ArchCare	76.00%	64.80%	60.77%	53.47%	86.67%
Catholic Health	100.00%	100.00%	100.00%	0.48%	100.00%[1]
CenterLight	90.79%	99.75%	59.05%	27.33%	98.49%
Complete Senior Care	83.87%	85.03%	84.86%	45.95%	65.88%
Eddy SeniorCare	98.59%	87.84%	89.63%	19.40%	100.00%
ElderONE	100.00%	99.77%	26.27%	7.18%	100.00%
Fallon Health	100.00%	28.47%	34.39%	100.00%	100.00%
PACE CNY	100.00%	100.00%	100.00%	100.00%	100.00%
Total Senior Care	76.92%	89.92%	9.03%	23.93%	100.00%

[1] Denominator=1.

External Quality Review Activity 2. Validation of Performance Measures

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	**External Quality Review Activity 2. Validation of Performance Measures**
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards

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

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

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

2022 Performance Measure Validation Summary

Validation Process

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

Validation Results

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

Performance Measure Rates

- Of the **Medicaid Advantage Plus** rates included in this report, **32% performed statistically significantly better** than statewide Managed Long-Term Care performance; **17% performed statistically significantly worse** than statewide Managed Long-Term Care performance; and **52% did not differ in performance** from statewide Managed Long-Term Care performance.
- Of the **Partial Capitation** rates included in this report, **43% performed statistically significantly better** than statewide Managed Long-Term Care performance; **33% performed statistically significantly worse** than statewide Managed Long-Term Care performance; and **24% did not differ in performance** from statewide Managed Long-Term Care performance.
- Of the **Program of All-Inclusive Care for the Elderly** rates included in this report, **39% performed statistically significantly better** than statewide Managed Long-Term Care performance; **20% performed statistically significantly worse** than statewide Managed Long-Term Care performance; and **41% did not differ in performance** from statewide Managed Long-Term Care performance.

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

Technical Summary – Validation of Performance Measures

Objectives

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

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

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for measurement year 2022.

Technical Methods of Data Collection and Analysis

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

For measurement year 2022, IPRO validated the Department of Health's ability to:

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

The *Community Health Assessment* measures selected for validation and presented in this report are displayed in Table 13.

Table 13: Community Health Assessment Categories and Measures

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

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

Description of Data Obtained

For the 2022 external quality review, the Department of Health provided IPRO with pertinent documentation to support the performance measure validation process, including final calculated rates. Specifically, IPRO received the *Dictionary of Selected Managed Long-Term Care Measures* (February 2023), the *full Data Dictionary for Uniform Assessment System for New York Version 1.16.x* (November 2023), a print version of *the Uniform*

Assessment System for New York Community Health Assessment (June 2023), and SAS® source code used by the Department of Health to calculate performance rates for the measures in Table 13.

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

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

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

Comparative Results

The results of IPRO's performance measure validation activities determined the Department of Health successfully calculated and reported rates for measurement year 2022 using data deriving from the *Uniform Assessment System for New York Community Health Assessment*. There were no issues found within the Department of Health's source code, and the coding logic abided by data dictionary requirements to accurately generate the desired calculations.

Table 14, Table 15, and Table 16 present Managed Long-Term Care plan performance measure rates for Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly, respectively. These tables also display statewide Managed Long-Term Care program performance. Managed Long-Term Care performance includes Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly.

Table 14: Medicaid Advantage Plus Performance Measure Results

Medicaid Advantage Plus Quality Measures and Rates						
Medicaid Advantage Plus	No Shortness of Breath	No Severe Daily Pain	Pain Controlled	Not Lonely or Not Distressed	Influenza Vaccination	Pneumococcal Vaccination
Statewide Managed Long-Term Care Average[1]	69%	96%	97%	98%	75%	77%
AgeWell	46%	96%	98%	100%	70%	57%
Centers Plan	51%	88%	99%	99%	77%	89%
Elderplan	43%	100%	99%	100%	76%	83%
Empire BCBS HealthPlus	93%	100%	100%	100%	70%	71%
Fidelis Care	74%	95%	97%	99%	65%	58%
Hamaspik	85%	98%	98%	98%	81%	77%
MetroPlus	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample
MHI Healthfirst	87%	99%	96%	96%	73%	71%
RiverSpring	48%	100%	89%	98%	80%	71%
Senior Whole Health	81%	100%	98%	100%	84%	83%
VillageCare	86%	100%	99%	99%	82%	81%
VNS Health	91%	100%	98%	100%	81%	86%

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

Green shading indicates that the managed care plan's 2022 performance is statistically significantly better than the Managed Long-Term Care statewide 2022 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions. **Red shading** indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2022 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Table 15: Partial Capitation Performance Measure Results

Partial Capitation Quality Measures and Rates						
Partial Capitation	No Shortness of Breath	No Severe Daily Pain	Pain Controlled	Not Lonely or Not Distressed	Influenza Vaccination	Pneumococcal Vaccination
Statewide Managed Long-Term Care Average[1]	69%	96%	97%	98%	75%	77%
Aetna	87%	97%	97%	99%	81%	82%
AgeWell	45%	99%	100%	100%	77%	77%
ArchCare	84%	99%	98%	99%	75%	76%
Centers Plan	49%	87%	98%	99%	78%	86%
Elderplan	48%	100%	99%	99%	73%	79%
Elderwood	47%	96%	92%	88%	65%	68%
Empire BCBS HealthPlus	88%	100%	99%	100%	78%	81%
EverCare	72%	93%	93%	97%	79%	80%
Extended MLTC	69%	100%	98%	100%	76%	77%
Fallon Health	44%	94%	86%	87%	55%	52%
Fidelis Care	76%	92%	97%	99%	67%	65%
Hamaspik	59%	99%	99%	99%	76%	83%
iCircle	45%	76%	80%	84%	70%	77%
Integra	79%	99%	98%	99%	78%	74%
Kalos Health	54%	97%	93%	90%	71%	84%
MetroPlus	90%	100%	98%	99%	83%	81%
Montefiore	67%	96%	90%	90%	81%	72%
Nascentia	54%	94%	93%	97%	70%	75%
Prime Health	66%	100%	100%	100%	84%	83%
RiverSpring	41%	100%	91%	98%	64%	59%
Senior Health Partners	88%	99%	97%	97%	70%	66%
Senior Network Health	35%	87%	88%	94%	76%	71%
Senior Whole Health	86%	100%	99%	99%	84%	85%
VillageCare	85%	100%	99%	99%	78%	78%
VNS Health	87%	99%	97%	99%	75%	80%

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

Green shading indicates that the managed care plan's 2022 performance is statistically significantly better than the Managed Long-Term Care statewide 2022 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions. **Red shading** indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2022 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

Table 16: Program of All-Inclusive Care for the Elderly Performance Measure Results

Program of All-Inclusive Care for the Elderly Quality Measures and Rates						
Program of All-Inclusive Care for the Elderly	No Shortness of Breath	No Severe Daily Pain	Pain Controlled	Not Lonely or Not Distressed	Influenza Vaccination	Pneumococcal Vaccination
Statewide Managed Long-Term Care Average[1]	69%	96%	97%	98%	75%	77%
ArchCare	87%	100%	99%	99%	86%	88%
Catholic Health	44%	96%	82%	89%	93%	89%
CenterLight	91%	100%	99%	99%	85%	67%
Complete Senior Care	25%	91%	81%	55%	85%	84%
Eddy SeniorCare	50%	97%	86%	91%	88%	88%
ElderONE	51%	95%	92%	94%	84%	76%
Fallon Health	39%	91%	76%	92%	72%	68%
PACE CNY	43%	97%	95%	88%	83%	76%
Total Senior Care	52%	80%	89%	69%	66%	65%

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

Green shading indicates that the managed care plan's 2022 performance is statistically significantly better than the Managed Long-Term Care statewide 2022 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions. **Red shading** indicates that the managed care plan's performance is statistically significantly worse than the Managed Long-Term Care statewide 2022 performance. Statistically significant differences between plan rates and the statewide rate were determined using analysis of proportions.

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

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	**External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards**

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

The Department of Health is responsible for making sure that the New York Managed Long-Term Care plans follow the Medicaid standards. The Department of Health continuously monitors the Managed Long-Term Care plans using a variety of mechanisms. The main way that the Managed Long-Term Care plans are monitored is through the Managed Care Operational Survey[11]. During the survey, the Department of Health reviews Medicaid managed care plan documents and interviews staff. The Medicaid managed care plan is responsible for fixing any issues found during the survey.

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

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

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a managed care plan's compliance with the standards set forth in *42 Code of Federal Regulations Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards*, the disenrollment requirements and limitations described in *42 Code of Federal Regulations 438.56*, the enrollee rights requirements described in *42 Code of Federal Regulations 438.*100, the emergency and post-stabilization services requirements described in *42 Code of Federal Regulations 438.114*, and the quality assessment and performance improvement requirements described in *42 Code of Federal Regulations 438.330*. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Department of Health conducts a variety of oversight activities to ensure that the managed care plans are in compliance with federal and state requirements and the applicable standards of *Title 42 Code of Federal Regulations Part 438 Managed Care*, *Partial Capitation Article V(F), Medicaid Advantage Plus Section 16.1-16.5, Program of All-Inclusive Care for the Elderly Article III. D*, *New York State Public Health Law Article 44* and *Article 49*, and *New York State Official Compilation of Codes, Rules, and Regulations Part 98-Managed Care Organizations*. These activities include the Managed Care Operational Survey and focused surveys. These survey activities center on the provision of long-term care services and are conducted for the Medicaid Advantage Plus and Partial Capitation managed care plans.

The review of Program of All-Inclusive Care for the Elderly managed care plan compliance with federal Medicaid standards is conducted and reported on by the Centers for Medicare & Medicaid Services[12]. A description of the Centers for Medicare & Medicaid Services' review, including objectives, technical methods of data collection and analysis, and corrective action plan process is in Appendix A of this report.

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

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services granted New York State a Section 1135 (under the Social Security Act) Waiver to suspend the requirements of *42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely. The granting of this waiver allowed the Department of Health to "pend" oversight activities that were scheduled for the remainder of 2020. While this allowance existed, the Department of Health did not pend oversight activities for Managed Long-Term Care plans and instead extended response times for the existing plans and existing focused surveys.

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

The results of the most recent compliance activities conducted for the Medicaid Advantage Plus and Partial Capitation managed care plans by the Department of Health and for the Program of All-Inclusive Care for the Elderly managed care plans by the Centers for Medicare & Medicaid Services are presented in this report.

Technical Methods of Data Collection and Analysis

Managed Care Operational Survey

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

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

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

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

- An evaluation of the Managed Long-Term Care plan's provision of services as it relates to enrollee safety, adequacy of care, utilization, and regulatory compliance.

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

Each Comprehensive Operational Survey was conducted in three phases:

Phase 1 - Comprehensive Operational Review

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

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

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

Phase 2 - Care Management Enrollee Record Review

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

Phase 3 - Survey Wrap-up

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

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

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

Focused Surveys

Appeals and Fair Hearing Survey

The Department of Health conducted a focused survey of internal appeal and fair hearing management practices for all Medicaid Advantage Plans and Partial Capitation plans. It is important to note that this activity evaluates Managed Long-Term Care plan compliance with a limited number of requirements under *Code of Federal Regulations 438.228 Grievance and appeal systems*.

Each Managed Long-Term Care plan was asked to submit a copy of organization policies and procedures for internal appeals and fair hearings, and to submit the dates of all appeals that resulted in a fair hearing anytime between March 1, 2021 and March 31, 2021. The Department of Health reviewed a sample of up to 40 member appeals records per Managed Long-Term Care plan to determine compliance with required timeframes associated with initial and final adverse determinations.

Statement of deficiencies were issued to the Managed Long-Term Care plans that demonstrated consistent noncompliance with timeframes for initial adverse determination, final adverse determinations, or sending fair hearing evidence packets.

Person-Centered Service Planning Survey

In January 2019 the Department of Health released guidance and templates for person-centered service planning to entities that provide home and community based services. This guidance highlighted and reinforced Managed Long-Term Care plan obligations relating to enrollee assessments, informal supports, and the development of the person-centered service plan and when the person-centered service plan must be provided to the enrollee.

In 2022 the Department of Health initiated a focused survey to assess Managed Long-Term Care plan compliance with the January 2019 guidance and template use. This focused survey was initiated on October 28, 2022 for all Medicaid Advantage Plans and Partial Capitation plans and included a review of the Managed Long-Term Care plans' current person-centered service plan templates, instructions, and attachments to the person-centered service plan.

Description of Data Obtained

Managed Care Operational Survey

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

Focused Surveys

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

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

The *Person-Centered Service Planning Survey Methodology* document included survey objectives, background, high-level results for the 2022 survey, and a list of Managed Long-Term Care plans that were included in the 2022 survey.

Comparative Results

Managed Care Operational Survey

When available, Managed Long-Term Care plan results for the Operational Survey activities are presented by federal Medicaid standards in Table 17, Table 18, and Table 19. In these tables, a "C" indicates that the Managed Long-Term Care plan was in compliance with all standard requirements and an "NC" indicates that the Managed Long-Term Care plan was not in compliance with at least one standard requirement. The details for each "NC" designation are presented in the Managed Long-Term Care Plan-Level Reporting section of this report.

Table 17: Medicaid Advantage Plus Managed Care Plan Compliance Survey Results

Medicaid Advantage Plus	Activity	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
AgeWell	2019-2022 Not Yet Scheduled														
Centers Plan	2019-2022 Not Yet Scheduled														
Elderplan	2019-2022 Not Yet Scheduled														
Empire BCBS HealthPlus	2019-2022 Not Yet Scheduled														
Fidelis Care	2019-2022 Not Yet Scheduled														
Hamaspik	2019-2022 Not Yet Scheduled														
MetroPlus	2019-2022 Not Yet Scheduled														
MHI Healthfirst	2019-2022 Not Yet Scheduled														
RiverSpring	2019-2022 Not Yet Scheduled														
Senior Whole Health	2019-2022 Not Yet Scheduled														
VillageCare	2019-2022 Not Yet Scheduled														
VNS Health	2019-2022 Not Yet Scheduled														

Table 18: Partial Capitation Managed Care Plan Compliance Survey Results

Partial Capitation	Activity	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Aetna	2020-2021 Comprehensive	C	C	C	C	C	NC	NC	NC	C	C	C	C	NC	C
AgeWell[1]	2019-2022 No Activity														
ArchCare	2019-2020 Comprehensive	C	C	C	C	C	NC	NC	NC	C	NC	NC	C	NC	C
Centers Plan	2020-2021 Comprehensive	C	C	C	C	C	C	C	NC	C	NC	C	C	NC	C
Elderplan	2019-2022 Not Yet Scheduled														
Elderwood	2019-2022 Not Yet Scheduled														
Empire BCBS HealthPlus	2019-2022 Not Yet Scheduled														
EverCare	2021-2022 Comprehensive	C	NC	C	C	C	NC	NC	C	C	C	C	C	NC	C
Extended MLTC	2019-2022 Not Yet Scheduled														
Fallon Health	2021-2022 Comprehensive	C	C	C	NC	C	NC	NC	NC	C	C	C	C	NC	C
Fidelis Care	2019-2022 Not Yet Scheduled														
Hamaspik	2019-2022 Not Yet Scheduled														
iCircle	2019-2020 Comprehensive	C	C	C	NC	C	NC	NC	NC	C	NC	NC	C	NC	C
Integra[2]	2019-2022 No Activity														
Kalos Health	2021-2022 Comprehensive	C	C	C	NC	C	NC	NC	NC	C	C	C	C	NC	C
MetroPlus	2019-2022 Not Yet Scheduled														

Partial Capitation	Activity	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Montefiore	2019-2022 Not Yet Scheduled														
Nascentia	2020-2021 Comprehensive	C	C	C	NC	C	NC	NC	C	C	C	C	C	C	C
Prime Health	2019-2022 Not Yet Scheduled														
RiverSpring	2020-2021 Comprehensive	C	C	C	C	C	NC	NC	C	C	C	C	C	NC	C
Senior Health Partners	2019-2022 Not Yet Scheduled														
Senior Network Health	2020-2021 Comprehensive	C	C	C	NC	C	NC	NC	NC	C	C	NC	C	C	C
Senior Whole Health	2019-2020 Comprehensive	C	C	C	C	C	NC	NC	NC	C	NC	NC	C	NC	C
VillageCare	2019-2022 Not Yet Scheduled														
VNS Health	2020-2021 Comprehensive	C	C	C	NC	C	NC	C	NC	C	C	NC	C	NC	C

[1] AgeWell New York Partial Capitation Plan was acquired by Senior Whole Health of New York MLTC Partial Capitation Plan on October 1, 2022

[2] Integra MLTC, Inc. Partial Capitation Plan was acquired by Empire Blue Cross Blue Shield HealthPlus MLTC Partial Capitation Plan on December 1, 2022.

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

Table 19: Program of All-Inclusive Care for the Elderly Managed Care Plan Compliance Survey Results

Program of All-Inclusive Care for the Elderly	Activity	438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
ArchCare	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
Catholic Health	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
CenterLight	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
Complete Senior Care	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
Eddy SeniorCare	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
ElderONE	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
Fallon Health	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
PACE CNY	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														
Total Senior Care	2020 No Activity[1]														
	2021 No Activity[1]														
	2022 No Activity[1]														

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

Focused Surveys

Appeals and Fair Hearing Survey

This activity evaluates Managed Long-Term Care plan compliance with a limited number of requirements under *Code of Federal Regulations 438.228 Grievance and appeal systems*. A determination of "in compliance" does not conclude that the Managed Long-Term Care plan is fully compliant with *Code of Federal Regulations 438.228 Grievance and appeal systems.* The results in Table 20 and Table 21 reflect Managed Long-Term plan compliance with timeframe requirements associated with adverse determinations, appeals, and fair hearings.

Table 20: Medicaid Advantage Plus Appeals and Fair Hearing Focused Survey Results, 2021-2022

Medicaid Advantage Plus	Activity	Appeals and Fair Hearing Survey Results
AgeWell	2021-2022 Focused Survey	In Compliance
Centers Plan	2021-2022 Focused Survey	In Compliance
Elderplan	2021-2022 Focused Survey	In Compliance
Empire BCBS HealthPlus	2021-2022 Focused Survey	In Compliance
Fidelis Care	2021-2022 Focused Survey	In Compliance
Hamaspik	2021-2022 Focused Survey	In Compliance
MHI Healthfirst	2021-2022 Focused Survey	Non-Compliance
RiverSpring	2021-2022 Focused Survey	In Compliance
Senior Whole Health	2021-2022 Focused Survey	Non-Compliance
VillageCare	2021-2022 Focused Survey	In Compliance
VNS Health	2021-2022 Focused Survey	Non-Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan. Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Table 21: Partial Capitation Appeals and Fair Hearing Focused Survey Results, 2021-2022

Partial Capitation	Activity	Appeals and Fair Hearing Survey Results
Aetna	2021-2022 Focused Survey	Non-Compliance
AgeWell	2021-2022 Focused Survey	Non-Compliance
ArchCare	2021-2022 Focused Survey	In Compliance
Centers Plan	2021-2022 Focused Survey	Non-Compliance
Elderplan	2021-2022 Focused Survey	Non-Compliance
Elderwood	2021-2022 Focused Survey	In Compliance
Empire BCBS HealthPlus	2021-2022 Focused Survey	In Compliance
EverCare	2021-2022 Focused Survey	Non-Compliance
Extended MLTC	2021-2022 Focused Survey	In Compliance
Fallon Health	2021-2022 Focused Survey	In Compliance
Fidelis Care	2021-2022 Focused Survey	In Compliance
Hamaspik	2021-2022 Focused Survey	In Compliance
iCircle	2021-2022 Focused Survey	Non-Compliance
Integra	2021-2022 Focused Survey	Non-Compliance
Kalos Health	2021-2022 Focused Survey	Non-Compliance
MetroPlus	2021-2022 Focused Survey	Non-Compliance
Montefiore	2021-2022 Focused Survey	In Compliance
Nascentia	2021-2022 Focused Survey	Non-Compliance
Prime Health	2021-2022 Focused Survey	In Compliance

Partial Capitation	Activity	Appeals and Fair Hearing Survey Results
RiverSpring	2021-2022 Focused Survey	In Compliance
Senior Health Partners	2021-2022 Focused Survey	Non-Compliance
Senior Network Health	2021-2022 Focused Survey	In Compliance
Senior Whole Health	2021-2022 Focused Survey	Non-Compliance
VillageCare	2021-2022 Focused Survey	Non-Compliance
VNS Health	2021-2022 Focused Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan. **Non-Compliance** means that at least one deficiency was issued to the Managed Long-Term Care plan.

Person-Centered Service Planning Survey

The Department of Health reported that a "general lack of compliance" was observed in the October 2022 survey for all Medicaid Advantage Plus plans and Partial Capitation plans. Reeducation and clarifying tools and webinars are scheduled to be conducted with the plans in 2023.

To assess the impact of Managed Long-Term Care on the quality of, timeliness of, and access to health care services, IPRO considered managed care plan responses to the 2021 external quality review recommendations, as well as plan-level results from the external quality review activities. Specifically, IPRO considered the following elements during the 2022 external quality review:

- Managed Long-Term Care Plan Follow-up on 2021 External Quality Review Recommendations
- External Quality Review Activity 1. Performance Improvement Projects, 2022
- External Quality Review Activity 2. Performance Measures, 2022
- External Quality Review Activity 3. Compliance with Medicaid and Children's Health Insurance Program Standards, 2020-2022

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCP, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each managed care plan describe how its organization addressed the recommendations from the *2021 External Quality Review Technical Report*. Managed Long-Term Care plan responses are reported in this section of the report.

Table 22 displays the assessment categories used by IPRO to describe Managed Long-Term Care plan progress towards addressing the 2021 external quality review recommendations.

Table 22: Managed Care Plan Response to Recommendation Assessment Levels

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

Performance Improvement Project Summary and Results, 2022

This section displays a comprehensive summary of the Managed Long-term Care plans' performance improvement projects that were in place in 2022. Each summary includes the project topic, the external quality review organization's validation statement, study populations, aims, a description of key interventions, and results achieved. The corresponding tables display performance indicators, baseline rates, interim rates, and targets/goals. A Managed Long-term Care plan's performance indicator showing improvement from the baseline

or meeting/exceeding the established target were considered strengths, while opportunities for improvement were noted when an indicator demonstrated performance decline from the baseline or did not meet the established target.

Performance Measures Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report. A Managed Long-Term Care plan meeting or exceeding the program average rate for a measure is considered a strength during the external quality review evaluation, while a Managed Long-Term Care plan rate reported below the program average rate is considered an opportunity for improvement.

Compliance with Medicaid Standards Results, 2020-2022

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

Strengths, Opportunities for Improvement, and Recommendations, 2022

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

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

The strengths and opportunities for improvement based on the Managed Long-Term Care plans' 2022 performance, as well as recommendations for improving quality, timeliness, and access to care are presented in this section (in table format). In these tables, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 23: AgeWell's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	AgeWell's Response	IPRO's Assessment of AgeWell's Response
Validation of Performance Improvement Projects		
Although Medicaid Advantage Plus enrollment was low, AgeWell should focus on opportunities where a quality improvement activity, such as a performance improvement project, would result in improved quality, timeliness, and/or access to care.	A disease management program was developed to prevent worsening of diseases (such as heart failure, chronic obstructive pulmonary disease, hypertension, and diabetes) to prevent potentially avoidable admission/readmissions and frequent emergency room visits with the following interventions. AgeWell's Quality Improvement Committee reviewed and evaluated all of their departments' performance metrics, the status of performance improvement programs, and identified areas requiring improvement. Grievances were resolved timely through provider education and collaboration.	Partially addressed.
Validation of Performance Measures		
AgeWell should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. AgeWell should also consider how to maximize realized positive outcomes of the assessment moratorium.	Face-to-face visits to conduct scheduled assessment/reassessment, post-hospitalization assessments, and significant change in condition assessments were placed on hold during the moratorium. Telephonic outreach was utilized instead, at least once per month, to conduct assessments, engage with members, identify barriers and potential hospital admission risks, close gaps-in-care, and promote preventive measures. Hence, prompt investigation and intervention of acute issues, care plan revision, and potential need for additional health care services were requested, coordinated, and authorized.	Partially addressed.
Review of Compliance with Medicaid Standards		
AgeWell should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Staff training is provided to ensure awareness and knowledge reinforcement of the regulatory requirements and mandates/guideline updates. AgeWell's Compliance Department has a program to monitor and ensure compliance with federal and state Medicaid standards. Departmental audits are done monthly for review and investigation. Corrective action plans are implemented and	Partially addressed.

2021 External Quality Review Recommendation	AgeWell's Response	IPRO's Assessment of AgeWell's Response
	enforced. HIPAA and compliance training are done upon start of employment and annually. Oversight of delegated entities are monitored.	
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, AgeWell should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Mock surveys are sent to AgeWell's Medicaid Advantage Plus population and the care manager's monthly engagement provides an opportunity to identify dissatisfaction and address areas of improvement. Appeals and grievances, care management, and utilization management directors collaborate with providers to ensure areas where members are dissatisfied are promptly resolved. AgeWell leveraged their business advisors' relationship with the partner providers to offer support in ensuring members are getting the appropriate care and their benefit maximized.	Partially addressed.

Table 24: AgeWell's Performance Improvement Project Summary, 2022

AgeWell's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ AgeWell aims to increase the social determinants of health screening rate of new enrollees within the first 30 days of enrollment. ▪ AgeWell aims to reduce the positive social determinants of health screening rate through quarterly social determinants of health assessments to follow-up on members' response to clinical and non-clinical interventions. ▪ AgeWell aims to increase the social determinants of health screening rate to identify social determinants of health issues among members. ▪ AgeWell aims to reduce positive social determinants of health among members with a positive social determinants of health screen. ▪ AgeWell aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted to reduce the rate of members with a positive social determinants of health screen and perform appropriate referrals and interventions. Managed Care Plan-Focused 2022 Interventions ▪ Developed and implemented a stand-alone social determinants of health assessment modeled after the Centers for Medicare and Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool. ▪ Created a tracking and reporting tool for identifying social determinants of health needs for members to initiate referrals, as well as a process for following up on referrals. ▪ Assembled a directory of community resources for members, which are available on the plan's website and distributed in member newsletters. ▪ Trained care managers on available community-based resources to help direct members with social determinants of health issues.

Table 25: AgeWell's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

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

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 26: AgeWell's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 27: AgeWell's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	AgeWell's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	AgeWell was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for AgeWell for measurement year 2022 performed statistically significantly worse than the statewide Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, AgeWell should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	AgeWell should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, AgeWell should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	AgeWell should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 28: Centers Plan's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Centers Plan's Response	IPRO's Assessment of Centers Plan's Response
Validation of Performance Improvement Projects		
Although Medicaid Advantage Plus enrollment was low, Centers Plan should focus on opportunities where a quality improvement activity, such as a performance improvement project, would result in improved quality, timeliness, and/or access to care.	Centers Plan has a comprehensive performance improvement program. In 2021, a transition of care project was put in place as it was recognized that a safe transition from inpatient admission to the community is essential for high-quality patient care and to reduce avoidable readmissions. Other projects included: an advance directive initiative with education and follow-up on execution; a fall prevention program for member safety; a dental, vision, and hearing screening initiative; a gaps-in-care initiative (diabetes and cancer screening); and a hypertension program for blood pressure management.	Partially addressed.
Validation of Performance Measures		
Centers Plan should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Centers Plan should also consider how to maximize realized positive outcomes of the assessment moratorium.	Centers Plan quickly implemented several changes to ensure continued support of its members, including: • COVID-19 education to identify any potential risks or impact to members. • Review of services to ensure each member was receiving authorized services and was safe in the community. • Focus on telehealth provider visits, which was a strong mitigating factor in decreasing the potential negative outcomes of the face-to-face assessment suspension. The flexibility to complete assessments via telehealth continues to remain advantageous to Center Plan's membership today.	Partially addressed.
Review of Compliance with Medicaid Standards		
Centers Plan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the	Centers Plan conducts auditing and monitoring activities to ensure compliance with federal and state Medicaid standards. Annually, a risk assessment is conducted and an audit plan is created. Centers Plan also has a Delegated	Partially addressed.

2021 External Quality Review Recommendation	Centers Plan's Response	IPRO's Assessment of Centers Plan's Response
compliance review conducted by the Department of Health.	Vendor Oversight Team that works with vendors to ensure that they are meeting quality standards and federal and state regulations. Centers Plan's Compliance Department participates in regulatory meetings to stay apprised of any changes that require an adjustment to current processes. These changes are monitored to ensure that they meet the new requirements.	
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, Centers Plan should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Centers Plan conducts annual internal member satisfaction surveys. Centers Plan's Quality Team reviews, reports, and follows up on internal survey feedback as well as the IPRO survey and managed long-term care consumer report results. Centers Plan maintains a Member Advisory Committee. This committee meets quarterly and is a platform for discussion of issues and potential resolutions. Centers Plan shares feedback from these meetings for process improvement. Centers Plan works together to coordinate a resolution when there is a report of an adverse member experience.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 29: Centers Plan's Performance Improvement Project Summary, 2022

Centers Plan's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Searching for Health Equity through Identification of Social Determinants of Health **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aim ▪ Centers Plan aims to complete a social determinants of health assessment for new and continuing enrollees, and improve the documentation of referrals and follow-up made for members at-risk for social determinants of health needs. Managed Care Plan-Focused 2022 Interventions ▪ Conducted care management training for all staff. ▪ Integrated an evidence-based social determinants of health assessment tool and referrals into Centers Plan's care management platform. ▪ Enhanced the care management system with automated reports to track social determinants of health assessment indicators. ▪ Created a comprehensive referral list for care management use based on social determinants of health needs.

Table 30: Centers Plan's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	78.54%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	95.93%	25.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	52.70%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.82%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	88.37%	45.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 31: Centers Plan's Medicaid Advantage Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 32: Centers Plan's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Centers Plan's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for Centers Plan for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Centers Plan was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Centers Plan for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Centers Plan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Centers Plan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Centers Plan should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Centers Plan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 33: Elderplan's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Elderplan's Response	IPRO's Assessment of Elderplan's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Elderplan should continue to address member utilization of these services and promote use of appropriate settings of care.	Hospital utilization remains a primary focus for Elderplan's Medicaid Advantage Plus plan. As such, readmission data are routinely analyzed and trended, with clinical interventions re-initiated based on trends, including programs that focus on congestive heart failure, diabetes mellitus, and sepsis. Provider-based trends are identified and high-acuity clinical rounding efforts are put in place with high-volume independent physician associations and home-visiting provider groups. Effects of such interventions are monitored for progress against targeted utilization metrics.	Partially addressed.
Validation of Performance Measures		
Elderplan should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Elderplan should also consider how to maximize realized positive outcomes of the assessment moratorium.	Elderplan did not observe negative health outcomes as a result of the moratorium. Elderplan's Interdisciplinary Team conducted frequent outreach to members to identify any changes in health status and to ensure continuity of services. Personal protective equipment was also provided. If a change in status was identified, a Uniform Assessment System for New York assessment was conducted, including via telehealth. Telehealth assessments are still being conducted if elected by a member and deemed appropriate by Elderplan.	Partially addressed.
Review of Compliance with Medicaid Standards		
Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Elderplan conducts routine monitoring, focusing on member impact whilst keeping operational documentation and processes up to date with requirements. Main risk topics include enrollment, care management, pre/post-service requests, appeals and grievances, network, contracting, pharmacy benefits/drug management program, quality improvement, marketing materials, vendor	Partially addressed.

2021 External Quality Review Recommendation	Elderplan's Response	IPRO's Assessment of Elderplan's Response
	oversight, fraud waste and abuse, and compliance. Elderplan successfully passed the Department of Health Article 44 Survey for 2021 activity.	
Administration of Quality-of-Care Surveys – Member Experience		
Elderplan should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Elderplan has implemented several initiatives to improve rating of transportation: post-reservation call surveys, automated trip reminders, dedicated call center representatives, text alerts for scheduled trips, increased courtesy trips, integration of Google time and distance estimates, a mobile transportation application, and Uber wheelchair-accessible vehicle service. These initiatives aim to provide a more streamlined, convenient, and reliable transportation experience and maintain a focus on service quality and member satisfaction.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 34: Elderplan's Performance Improvement Project Summary, 2022

Elderplan's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aim ▪ Elderplan aims to increase the percentage of members with social determinants of health assessments among new and continuously enrolled members. Member-Focused 2022 Interventions ▪ Developed individualized care plans with targeted interventions for members with needs by the social determinants of health tool. Managed Care Plan-Focused 2022 Interventions ▪ Enhanced annual training program to include social determinants of health tool and available community resources. ▪ Updated workflow to include requirement to complete social determinants of health screening tool at least once a year.

Table 35: Elderplan's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	93.65%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	98.50%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	10.76%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	72.50%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 36: Elderplan's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 37: Elderplan's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderplan's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Elderplan for measurement year 2022 performed statistically significantly better than the statewide Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderplan was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for Elderplan for measurement year 2022 performed statistically significantly worse than the statewide Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Elderplan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Elderplan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderplan should focus on enhancing areas of care where its rates are below the Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 38: Empire BCBS HealthPlus's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, in order to allow for a more thorough assessment of its interventions and implementation approach, Empire BCBS HealthPlus should continue its work related to this project for another year. This will allow for an additional point of measurement for the performance indicators, as well as more data points to track the progress of interventions.	In 2021, Empire BCBS HealthPlus's performance improvement project topic was on emergency room visits/hospitalization reduction. In 2023, there was a resubmission of our 2021 data which showed Empire BCBS HealthPlus meeting its targeted goals. Integra merged with Empire BCBS HealthPlus, who has now adopted the prior Integra Transition of Care performance improvement project. Empire BCBS HealthPlus's readmission rate in quarter 2 of 2023 was 14.65, with June at 10.67. Empire BCBS HealthPlus will continue to monitor.	Partially addressed.
Validation of Performance Measures		
Empire BCBS HealthPlus should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Empire BCBS HealthPlus should also consider how to maximize	Empire BCBS HealthPlus's members were contacted monthly to assess their needs and safety in the community. If a member requested a change in their plan of care, the care manager collaborated with the member's community health team for updated information on the member. Empire BCBS HealthPlus utilized medical director rounds to discuss cases and did not find a negative impact from the moratorium. Currently, Integra is now Empire BCBS HealthPlus, and they are doing Uniform Assessment System for New	Addressed.

2021 External Quality Review Recommendation	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
realized positive outcomes of the assessment moratorium.	York assessments via telehealth and in-person assessments.	
Review of Compliance with Medicaid Standards		
Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Empire BCBS HealthPlus had no Department of Health audits during 2022. Empire BCBS HealthPlus did conduct internal audits and monitoring in areas of contractual compliance. These findings were reported at quarterly Quality Committee meetings. Opportunities for improvement were identified and plans for improvement were presented. Committee membership shared recommendations on strategies for improvement.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, Empire BCBS HealthPlus should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	IPRO did not survey the Medicaid Advantage Plus population due to its small sample size. Empire BCBS HealthPlus has utilized an internal member satisfaction survey that was and continues to be sent to members bi-annually. The objective of the survey is to obtain real-time data from members on areas that may need improvement. Empire BCBS HealthPlus established a Member Engagement Committee to develop improvement strategies as needed.	Partially addressed.

Table 39: Empire BCBS HealthPlus's Performance Improvement Project Summary, 2022

Empire BCBS Healthplus's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ Empire BCBS HealthPlus aims to increase the percentage of completed social determinants of health screenings and interventions for managed long-term care and fully integrated dual eligible members. Member-Focused 2022 Interventions ▪ Developed and distributed education materials and social determinants of health toolkits for member communication that include local resources and available programs related to social determinants of health. Managed Care Plan-Focused 2022 Interventions ▪ Educated staff on the prevalence and health impacts of social determinants of health among the managed long-term care population. ▪ Created system-generated reports to allow care managers to monitor and track identified social determinants of health needs and interventions. ▪ Trained care management staff on the social determinants of health screening tool and tracking interventions. ▪ Educated managed long-term care service providers (licensed home care services agencies) on social determinants of health needs and health plan's interventions.

Table 40: Empire BCBS HealthPlus's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	36.56%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	75.38%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	97.38%	10.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	22.82%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	75.00%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 41: Empire BCBS HealthPlus's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 42: Empire BCBS HealthPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Empire BCBS HealthPlus's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Empire BCBS HealthPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Empire BCBS HealthPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Empire BCBS HealthPlus should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 43: Fidelis Care's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Fidelis Care should continue to address member utilization of these services and promote use of appropriate settings of care.	Fidelis Care has continued to monitor member utilization of both emergency departments and hospitalizations. Care management monitors utilization through monthly calls and the regional health information organization (Healthix). Member education materials are provided to the member on utilization of the proper level of care and follow-up with their primary care provider for non-emergency situations. Fidelis Care conducts monthly member record reviews to monitor utilization and care management follow-up.	Partially addressed.
Validation of Performance Measures		
Fidelis Care should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Fidelis Care should also consider how to maximize realized positive outcomes of the assessment moratorium.	The moratorium prevented plans from conducting routine reassessments and in-home, face-to-face visits for approximately two years. Fidelis Care conducted telephonic assessments which were valid for 90 days and thus resulted in more frequent assessments. In March 2021, Fidelis Care conducted virtual assessments of its members in lieu of in-home visits during the COVID-19 pandemic. Fidelis Care also conducted monthly care management calls with members to review their care and provide education as needed.	Partially addressed.
Review of Compliance with Medicaid Standards		
Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Fidelis Care has robust routine monitoring to ensure compliance with federal and state standards. Fidelis Care conducts semiannual mock survey reviews of a randomized sampling of member records. Results of the mock surveys are reported to Fidelis Care's Compliance Department for reviewing and monitoring.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey,	Fidelis Care has added member satisfaction questions to the monthly call template. All staff	Partially addressed.

2021 External Quality Review Recommendation	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Fidelis Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	have gone through customer satisfaction education. Calls with members are reviewed for customer service, accuracy, and documentation. Member input regarding satisfaction is a regular part of quarterly Participant Advisory Committee meetings. Member concerns are addressed and members are provided follow-up to address their concerns.	

Table 44: Fidelis Care's Performance Improvement Project Summary, 2022

Fidelis Care's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among new enrollees within the first 30 days of enrollment. ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among continuously enrolled members. ▪ Fidelis Care aims to increase the percentage of care manager contacts where a stand-alone social determinants of health screening was conducted. ▪ Fidelis Care aims to increase the percentage of members with documented action taken to address need(s). Member-Focused 2022 Interventions ▪ Published a member newsletter article on social determinants of health resources. ▪ Linked members identified with a positive social determinants of health assessment to appropriate resources based on member need. Managed Care Plan-Focused 2022 Interventions ▪ Updated care management workflow to include member education on the importance of completing assessments. ▪ Educated staff on the impact of social determinants of health, assessment tools, and resources available.

Table 45: Fidelis Care's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	47.87%	70.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	82.64%	70.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	76.68%	90.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	17.58%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	90.63%	35.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 46: Fidelis Care's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 47: Fidelis Care's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	Fidelis Care was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures	One performance measure rate calculated by the Department of Health for Fidelis Care for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fidelis Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Fidelis Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fidelis Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 48: Hamaspik's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Hamaspik's Response	IPRO's Assessment of Hamaspik's Response
Validation of Performance Improvement Projects		
Although Medicaid Advantage Plus enrollment was low, Hamaspik should focus on opportunities where a quality improvement activity, such as a performance improvement project, would result in improved quality, timeliness, and/or access to care.	Since the implementation of the social determinants of health performance improvement project in the last quarter of 2021, Hamaspik has implemented workflows, systems of support, education, and reporting that supports the actionable utilization of the social determinants of health data, which drives initiatives and interventions to improve the access-of-care for Hamaspik's Medicaid Advantage Plus membership.	Partially addressed.
Validation of Performance Measures		
Hamaspik should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Hamaspik should also consider how to maximize realized positive outcomes of the assessment moratorium.	In lieu of reassessments, Hamaspik completed virtual reassessments similar to the Uniform Assessment System for New York assessments but completed by internal nurses to ensure that all members' needs were reviewed and their care plans were updated accordingly. Hamaspik also added remote support groups for members to assist them with social interaction during the COVID-19 pandemic. Hamaspik also minimized negative health outcomes by creating a 1-Visit Program, where members were connected with a home-visiting provider.	Addressed.
Review of Compliance with Medicaid Standards		
Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Hamaspik's Compliance Department conducts a range of internal audits each month, which ensures that regulatory requirements are met. These audits include (but are not limited to) the review of enrollment and disenrollment documentation, care management activities, utilization management processes and member notices, member services, billing, and claims payment. The audit reports are reviewed during Hamaspik's Compliance Committee meetings and identified areas for improvement are addressed.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		

2021 External Quality Review Recommendation	Hamaspik's Response	IPRO's Assessment of Hamaspik's Response
Despite its small sample size for the member satisfaction survey, Hamaspik should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Hamaspik will be conducting a mock survey to assess access to care, the Rating of Health Plan measure, as well as other measures to put plans in place that will address this population.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 49: Hamaspik's Performance Improvement Project Summary, 2022

Hamaspik's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for new members within the first 30 days of enrollment. ▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for members who have been continuously enrolled with the plan. ▪ Hamaspik aims to improve the rate of care manager contacts where a social determinants of health screen is conducted. ▪ Hamaspik aims to determine the percentage of members who have a positive social determinants of health assessment. ▪ Hamaspik aims to improve the rate of members with a positive social determinants of health assessment who have documented interventions to address the identified need(s). Provider-Focused 2022 Intervention ▪ Collaborated with in-network home care services agencies and primary care providers to engage members with positive social determinants of health indicators. Managed Care Plan-Focused 2022 Interventions ▪ Integrated a social determinants of health assessment tool within Hamaspik's electronic medical record system that enables direct reporting of the performance improvement project's indicators. ▪ Modified existing workflows and developed new workflows to support the social determinants of health assessment. ▪ Trained care managers on social determinants of health.

Table 50: Hamaspik's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	18.95%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	Not Available	25.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	1.61%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	72.22%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 51: Hamaspik's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 52: Hamaspik's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Hamaspik's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	Hamaspik was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Hamaspik should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Hamaspik should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Hamaspik should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

MetroPlus did not participate in the Medicaid Advantage Plus program in 2021.

Performance Improvement Project Summary and Results, 2022

Table 53: MetroPlus's Performance Improvement Project Summary, 2022

MetroPlus's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ MetroPlus aims to increase the rate for social determinants of health screening among new members. ▪ MetroPlus aims to increase the rate for social determinants of health screening among continuously enrolled members. ▪ MetroPlus aims to increase subsequent follow-up to address social determinants of health needs among members with a positive screen using clinical and non-clinical interventions. Member-Focused 2022 Intervention ▪ Monitored members with a positive social determinants of health assessment to ensure implementation of at least one intervention. Managed Care Plan-Focused 2022 Interventions ▪ Enabled a system generated report to support quarterly monitoring of members with social determinants of health needs. ▪ Trained care managers on the use of the social determinants of health screening tool and appropriate selection of interventions.

Table 54: MetroPlus's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Medicaid Advantage Plus Enrollment	13.64%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Medicaid Advantage Plus Enrollment	95.00%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Medicaid Advantage Plus Enrollment	7.01%	50.00%
Percentage of members with a positive social determinants of health assessment	No Medicaid Advantage Plus Enrollment	0.00%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Medicaid Advantage Plus Enrollment	0.00%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

MetroPlus did not participate in the Medicaid Advantage Plus program at the time the 2021-2022 Appeals and Fair Survey was conducted.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 55: MetroPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates demonstrated a static rate between measurement years 2021 and 2022.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MetroPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	MetroPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.	X	X	X
Compliance with Federal Managed Care Standards	MetroPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 56: MHI Healthfirst's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	MHI Healthfirst's Response	IPRO's Assessment of MHI Healthfirst's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, MHI Healthfirst should continue to address member utilization of these services and promote use of appropriate settings of care.	Health information exchange integration has been expanded, along with notification of inpatient/emergency department admissions for discharge planning and coordination of care post-discharge. A clinical application tool was created that displays healthcare services received, labs, HEDIS, medication adherence and managed long-term care preventative gaps-in-care to facilitate care planning, education, and coordination. A clinical education and training team was created and clinical resources added to develop clinical acumen of care managers.	Partially addressed.
Validation of Performance Measures		
MHI Healthfirst should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. MHI Healthfirst should also consider how to maximize realized positive outcomes of the assessment moratorium.	A clinical application tool was created, layered over the electronic medical record exposing lab results, medication adherence, HEDIS and/or managed long-term care gaps-in-care for education, and coordination of preventative screenings. A comprehensive telephonic assessment has been implemented to continue assessing members for changes in condition or decline, and specialized diabetes and social determinants of health assessments have been developed with care planning pathways to support social determinants of health barriers, or gaps in knowledge/services and clinical decline.	Partially addressed.
Review of Compliance with Medicaid Standards		
MHI Healthfirst should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019 compliance findings. Healthfirst should conduct internal reviews as it prepares for the	MHI Healthfirst has a robust internal corrective action process to mitigate issues and prevent repeat occurrences. The 2019 internal corrective action plans have been successfully implemented and closed. All relevant business units review prior results to confirm compliance with federal and state Medicaid standards. In addition, MHI Healthfirst's Compliance and Regulatory Teams	Partially addressed.

2021 External Quality Review Recommendation	MHI Healthfirst's Response	IPRO's Assessment of MHI Healthfirst's Response
compliance review conducted by the Department of Health.	work collaboratively to monitor and review ongoing compliance.	
Administration of Quality-of-Care Surveys – Member Experience		
MHI Healthfirst should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	MHI Healthfirst has implemented a multi-pronged strategy to improve member satisfaction, including training care management staff to use motivational interviewing, adding probing questions to the proxy member satisfaction survey to ensure care managers address all member needs during monthly outreach calls, and regularly reviewing member feedback to continue to enhance the overall experience both with care managers and home health aides.	Partially addressed.

Table 57: MHI Healthfirst's Performance Improvement Project Summary, 2022

MHI Healthfirst's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ MHI Healthfirst aims to improve the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ MHI Healthfirst aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ MHI Healthfirst aims to improve the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ MHI Healthfirst aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. Member-Focused 2022 Intervention ▪ Provided educational information on the importance of addressing social determinants of health barriers in achieving positive health outcomes and a compilation of online and community resources on our member website. ▪ Conducted follow-up outreach to members within 30 days of the implementation of an intervention addressing a social determinant of health barrier. Managed Care Plan-Focused 2022 Interventions ▪ Integrated a social determinants of health screening tool within MHI Healthfirst's care management software, TruCare, that assesses housing instability, safety, food insecurity, social isolation, and financial hardship. ▪ Enhanced care planning functionality in the care management system that triggers an intervention/referral which is evidence-based in addressing a social determinants of health need. ▪ Developed a care management workflow that ensures the social determinants of health screening of managed long-term care members within 30 days of enrollment, and annually for members enrolled longer than six months. ▪ Facilitated training and developed a job aide to educate case management staff on the new tools for social determinants of health screening/care planning, as well as the social determinants of health workflow.

Table 58: MHI Healthfirst's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	26.25%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	83.09%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	11.84%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	10.02%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	74.23%	75.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 59: MHI Healthfirst's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** MHI Healthfirst failed to consistently respond to member service authorization requests within the required timeframe. **Deficiency 2:** MHI Healthfirst failed to consistently respond to member service appeals within the required timeframe.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 60: MHI Healthfirst's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MHI Healthfirst's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Healthfirst for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Four performance measure rates calculated by the Department of Health for MHI Healthfirst for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	MHI Healthfirst was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MHI Healthfirst should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	MHI Healthfirst should utilize the findings from the Department of Health's analysis of health	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Healthfirst should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	MHI Healthfirst should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 61: RiverSpring's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	RiverSpring's Response	IPRO's Assessment of RiverSpring's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, RiverSpring should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	RiverSpring nurse care managers coordinate care when RiverSpring is notified by speaking with the facility, designated representative, and/or the member during the event to anticipate the discharge needs. The nurse care manager assists the member with scheduling follow-up appointments, ensures all supplies and equipment are in place, and provides education on medications and managing their illness to prevent future hospitalizations. A Uniform Assessment System assessment will be completed, if appropriate, and the care plan updated.	Partially addressed.
Validation of Performance Measures		
RiverSpring should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. RiverSpring should also consider how to maximize realized positive outcomes of the assessment moratorium.	RiverSpring continued the comprehensive assessment with a review of the person-centered service plan every 6 months and as needed to assess for needed changes based on the member's needs. This way, RiverSpring was able to provide member-centric, individualized care throughout the moratorium. RiverSpring nurse care managers also have a collaborative relationship with their members. Telehealth utilization increased by industry as a result of the moratorium; it could be a tool used by the nurse care manager when a face-to-face visit is urgent.	Partially addressed.
Review of Compliance with Medicaid Standards		
RiverSpring should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	RiverSpring routinely conducts internal and external reviews of key performance indicators and shares results with stakeholders to identify any variations from regulations and established workflow so an item is then addressed to ensure high-quality care is delivered to the membership. Corrective action	Partially addressed.

2021 External Quality Review Recommendation	RiverSpring's Response	IPRO's Assessment of RiverSpring's Response
	plans have been implemented to address past deficiencies.	
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, RiverSpring should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	RiverSpring has a partnership with their members, working together to ensure members have all the services and supports needed to improve their health and quality of life. This shows in the results of the member satisfaction survey where RiverSpring is performing better than most plans. RiverSpring recognizes many of their members are hesitant to discuss or create a document for appointing health decisions and have again launched an education campaign to inform and support members in stating their preferences.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 62: RiverSpring's Performance Improvement Project Summary, 2022

RiverSpring's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessment within the first 30 days of enrollment for all new Medicaid Advantage Plus members. ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessments for all continuously enrolled Medicaid Advantage Plus members. ▪ RiverSpring aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted for all newly and continuously enrolled Medicaid Advantage Plus members. ▪ RiverSpring aims to decrease the percentage of positive social determinants of health assessments for all newly and continuously enrolled Medicaid Advantage Plus members. ▪ RiverSpring aims to increase the percentage of documented interventions to address needs for all Medicaid Advantage Plus members with a positive social determinants of health assessment. Member-Focused 2022 Interventions ▪ Added a recurring section to the member newsletter on social determinants of health to provide ongoing education and resources to members. ▪ Added social determinants of health education to be discussed on monthly care management calls to members. Managed Care Plan-Focused 2022 Interventions ▪ Trained staff on the social determinants of health screening tool, the prevalence and health impacts of social determinants of health, and community resources, which will be repeated annually for all staff and at orientation for new hires. ▪ Constructed a searchable inventory of local resources and supports organized by location and need. ▪ Integrated the social determinants of health assessment tool into existing systems utilized by care management. ▪ Developed a monitoring system within existing care management systems and workflows to ensure close-loop process for referring members to community services and supports.

Table 63: RiverSpring's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	38.52%	45.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	37.40%	40.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	8.82%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	8.60%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	44.44%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 64: RiverSpring's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 65: RiverSpring's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	RiverSpring's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	RiverSpring was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Two performance measure rates calculated by the Department of Health for RiverSpring for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, RiverSpring should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	RiverSpring should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, RiverSpring should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	RiverSpring should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 66: Senior Whole Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Senior Whole Health's Response	IPRO's Assessment of Senior Whole Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Senior Whole Health should continue to monitor member utilization and promote use of appropriate settings of care.	Senior Whole Health continues to monitor member utilization with the following methods implemented since 2021. ▪ The Member Health Intelligence Portal is used to track hospitalizations. ▪ As of 2021, Senior Whole Health continues to enroll members in the Disease Management/Fall Prevention Programs based on diagnosis and/or emergency room/hospitalization utilization. ▪ There are monthly care management contacts for education and follow-up. ▪ Senior Whole Health has a Transitions of Care Team teaching and monitoring for 30 days post-hospital discharge.	Partially addressed.
Validation of Performance Measures		
Senior Whole Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Senior Whole Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	Senior Whole Health assessment nurses resumed community health assessments annually as of May 2021. Additionally, the Medicaid Advantage Plus population resumed face-to-face behavioral health assessments for members with an H9 code. In order to maximize positive outcomes, Senior Whole Health implemented daily monitoring of a member's activity via the Member Health Intelligence Portal alerting the care manager to changes in condition, such as falls, pain, emergency room visits, etc.	Partially addressed.
Review of Compliance with Medicaid Standards		
Senior Whole Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review	Senior Whole Health conducts various internal reviews throughout the year to ensure compliance. Self-monitoring/auditing by department occurs at different frequencies throughout the year. Senior Whole Health's Compliance Department conducts an annual risk assessment, which in turn, develops the internal audit work plan, and quarterly audits	Partially addressed.

2021 External Quality Review Recommendation	Senior Whole Health's Response	IPRO's Assessment of Senior Whole Health's Response
conducted by the Department of Health.	are conducted; corrective action plans are issued for non-compliance.	
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, Senior Whole Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Senior Whole Health's Quality Department monitors member experience for its population through analysis of various data sources. Senior Whole Health's Enrollee Advisory and Member Safety Committees allow members to actively provide feedback on utilization and quality-of-care experiences. Additionally, Senior Whole Health is currently implementing a quarterly member outreach program to proactively follow-up with members who have specifically voiced quality-of-care concerns.	Addressed.

Table 67: Senior Whole Health's Performance Improvement Project Summary, 2022

Senior Whole Health's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ Senior Whole Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Whole Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ Senior Whole Health aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). Managed Care Plan-Focused 2022 Interventions ▪ Developed discreet data reporting from the National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences tool to readily allow for identification of members with social determinants of health needs. ▪ Developed, documented, and tracked a comprehensive member referral process to access, link, and coordinate members with identified social determinants of health needs. ▪ Performed a clinical quality audit regarding social determinants of health outcomes. ▪ Trained all care management and quality staff on social determinants of health and the Responding to and Assessing Patients' Assets, Risks and Experiences standardized assessment tool and workflow process.

Table 68: Senior Whole Health's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	0.00%	75.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	84.90%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	20.30%	48.80%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.20%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	87.50%	87.50%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 69: Senior Whole Health's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Senior Whole Health failed to consistently respond to member service appeals within the required timeframe.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 70: Senior Whole Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Whole Health's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates did not demonstrate improvement or met the target rate.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	Senior Whole Health was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Whole Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Senior Whole Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	access to care, or experienced unfavorable health outcomes. To address this, Senior Whole Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Senior Whole Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 71: VillageCare's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	VillageCare's Response	IPRO's Assessment of VillageCare's Response
Validation of Performance Improvement Projects		
Although Medicaid Advantage Plus enrollment was low, VillageCare should focus on opportunities where a quality improvement activity, such as a performance improvement project, would result in improved quality, timeliness, and/or access to care.	Beginning in 2022, VillageCare included their Medicaid Advantage Plus plan in the current performance improvement project for social determinants of health. In addition, VillageCare collects and analyzes quality improvement and member satisfaction metrics for their Medicaid Advantage Plus plan on a quarterly basis. These metrics are reported to their Quality Management Improvement Committee.	Partially addressed.
Validation of Performance Measures		
VillageCare should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. VillageCare should also consider how to maximize realized positive outcomes of the assessment moratorium.	During the moratorium, VillageCare continued to assess members every six months telephonically to identify changes in condition. Throughout the moratorium, VillageCare worked closely with community partners and their internal Pharmacy Team to prevent negative outcomes and promote medication adherence. When the moratorium was lifted, VillageCare worked to complete the backlog of reassessments to identify and address any needs.	Addressed.
Review of Compliance with Medicaid Standards		
VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	VillageCare's Quality Management Department has developed a Quality Management Program and Workplan which outlines the required standards and metrics for the Medicaid Advantage Plus plan. In addition, the Quality Management Program and Workplan identify the stakeholders responsible for ensuring compliance with the standards. The metrics are reported to the Quality Management Improvement Committee quarterly. When goals are	Partially addressed.

2021 External Quality Review Recommendation	VillageCare's Response	IPRO's Assessment of VillageCare's Response
	not met, a corrective action plan is required, and the Quality Management Department follows the corrective action plan through to resolution.	
Administration of Quality-of-Care Surveys – Member Experience		
VillageCare should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	For VillageCare's Medicaid Advantage Plus plan, the member satisfaction scores were in line with the statewide average for all measures except where the sample size was too small. Since this survey, VillageCare has implemented improvement activities that include developing and distributing member educational materials and discussing advanced directives during monthly calls and member health events. VillageCare encourages members to formulate an advance directive and to provide a copy to VillageCare.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 72: VillageCare's Performance Improvement Project Summary, 2022

VillageCare's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ VillageCare aims to increase stand-alone completed social determinants of health assessments for all members both newly enrolled and continuously enrolled. ▪ VillageCare aims to increase the percentage of care manager contacts where social determinants of health assessments is conducted and decrease the number of positive social determinants of health assessments. ▪ VillageCare aims to increase the number of members with positive social determinants of health assessments who have documented intervention(s). Managed Care Plan-Focused 2022 Interventions ▪ Conducted follow-up outreach to members with a positive social determinant of health within 90 days of a referral. ▪ Developed educational tools for care managers related to social determinants of health. ▪ Trained care managers on the social determinants of health assessments and community-based organization information.

Table 73: VillageCare's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	89.13%	≥90%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	12.63%	≥90%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	31.74%	Not Required
Percentage of members with a positive social determinants of health assessment	No Data To Report	34.82%	≤50%
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	9.60%	≥90%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 74: VillageCare's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 75: VillageCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VillageCare's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	All performance measure rates calculated by the Department of Health for VillageCare for measurement year 2022 performed statistically significantly better than the statewide Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	VillageCare was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VillageCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	VillageCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assurance and performance improvement program.			
Compliance with Federal Managed Care Standards	VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 76: VNS Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	VNS Health's Response	IPRO's Assessment of VNS Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, VNS Health should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	VNS Health continues efforts in strengthening processes established during the Transition of Care performance improvement plan. VNS Health enhanced workflows for better adoption of ADT admission alerts and member outreach following emergency department visits to support transitional care coordination and reduce admissions. Starting in quarter 4 of 2023, VNS Health will begin utilizing the new provider portal to support communication with providers. Ongoing key performance indicator monitoring will be conducted during quality committees with stakeholders.	Partially addressed.
Validation of Performance Measures		
VNS Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. VNS Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	Since March 2020, VNS Health began to assess members through virtual means, both annually and when a significant change in condition is identified. This allows VNS Health to continue monitoring members' needs, adjust plans of care, and implement appropriate interventions. VNS Health's goal is to ensure members continue to receive the appropriate care needed and to maintain their wellbeing in the community. VNS Health continues to track assessment due dates and performing significant change in condition assessments.	Addressed.
Review of Compliance with Medicaid Standards		
VNS Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Starting in 2021, VNS Health implemented strategies for continued oversight and ongoing monitoring for alignment with Department of Health requirements. Dashboards are utilized weekly and/or monthly for tracking and validation of metrics. Regular audits occur to review consumer directed personal assistance service	Partially addressed.

2021 External Quality Review Recommendation	VNS Health's Response	IPRO's Assessment of VNS Health's Response
	orders, claims, service utilization, care coordination, and member satisfaction, to ensure accuracy and maintain timeframes determined by the Department of Health.	
Administration of Quality-of-Care Surveys – Member Experience		
VNS Health should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	VNS Health incorporated satisfaction measures into their contracts with providers to help increase collaboration and partnership with personal care agencies to improve member experience. VNS Health will also administer an off-cycle satisfaction survey on an annual basis to understand the root cause of member satisfaction results. Survey results will be shared with relevant stakeholders to design and implement improvement plans which will be monitored on a regular basis.	Partially addressed.

Table 77: VNS Health's Performance Improvement Project Summary, 2022

VNS Health's Medicaid Advantage Plus Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Medicaid Advantage Plus
Aims ▪ VNS Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ VNS Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ VNS Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ VNS Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). Member-Focused 2022 Interventions ▪ Referred members with diabetes and a positive social determinants of health assessments for home delivered meals. ▪ Referred members with diabetes and a positive social determinants of health assessment to social adult day care. ▪ Published an article on social determinants of health in the member newsletter. Provider-Focused 2022 Interventions ▪ Conducted an online course educating provider attendees on Total Over the Counter card and grocery benefits. Managed Care Plan-Focused 2022 Interventions ▪ Educated the care management team on Healthify, which provides resources available to aid care managers in linking members to community resources and services not covered by VNS Health. ▪ Educated the care management team on the appropriate use of the enhanced social determinants of health assessment and follow-up workflow procedures.

Table 78: VNS Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	21.90%	15.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	72.18%	15.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	7.80%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	9.67%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	56.50%	53.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 79: VNS Health's Medicaid Advantage Plus Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** VNS Health failed to consistently respond to service authorization requests within the required timeframe. **Deficiency 2:** VNS Health failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 80: VNS Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VNS Health's performance improvement project for the Medicaid Advantage Plus population passed validation for measurement year 2022.			
Performance Measures	All performance measure rates calculated by the Department of Health for VNS Health for measurement year 2022 performed statistically significantly better than the statewide Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	VNS Health was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VNS Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	VNS Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	VNS Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Partial Capitation Managed Care Plan-Level Reporting

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 81: Aetna's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Aetna's Response	IPRO's Assessment of Aetna's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Aetna should continue to monitor member utilization and promote use of appropriate settings of care.	Aetna agrees. Aetna partnered with Healthix to provide real-time hospitalization data for members, to help manage their diseases and improve their health and wellness. This also allows Aetna to institute targeted interventions to help prevent recurring hospitalizations. Aetna has been engaging members more to obtain their consent for the use of Healthix. Aetna expects that this activity will help reduce hospitalizations.	Partially addressed.
Validation of Performance Measures		
Aetna should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Aetna should also consider how to maximize realized positive outcomes of the assessment moratorium.	The moratorium initially created a hardship on members who could not be reassessed. Aetna worked quickly to address the moratorium by implementing telehealth practices. While not a perfect solution, it was the only option available that would provide some services to members. Aetna is continually evaluating ways to improve actions that will provide positive outcomes for our members.	Addressed.
Review of Compliance with Medicaid Standards		
Aetna should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Aetna should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Aetna has increased its focus on areas that were identified as deficient during its last site survey. This has resulted in new policies and procedures for the areas identified to help ensure improvement in those areas. Aetna has also increased its monitoring of activity and data in those affected areas to help improve the outcomes in areas identified as deficient. Aetna has also refocused efforts on social day care and the auditing of those centers.	Partially addressed.

2021 External Quality Review Recommendation	Aetna's Response	IPRO's Assessment of Aetna's Response
Administration of Quality-of-Care Surveys – Member Experience		
Aetna should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	Aetna is currently conducting an internal process improvement plan focused on educating members on advance care planning and executing advance directives. This education can benefit members in helping them and their family in completing their advance directives. The interventions generally focus on language and cultural barriers since a significant member population speaks a language other than English as their primary language.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 82: Aetna's Performance Improvement Project Summary, 2022

Aetna's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Aetna aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Aetna aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Aetna aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Aetna aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. Member-Focused 2022 Interventions ▪ Educated members on the components of social determinants of health during quarterly Member Advisory Committee meetings. ▪ Conducted quarterly outreach via telephone to provide member education on social determinants of health, including available programs and benefits. Managed Care Plan-Focused 2022 Interventions ▪ Informed care management staff on community-based organizations and resources for social determinants of health. ▪ Incorporated social determinants of health resources into Aetna's care management platform.

Table 83: Aetna's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	45.15%	65.90%	76.75%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	6.65%	8.09%	9.31%
Percentage of care manager contacts where a social determinants of health screen is conducted	0.00%	0.01%	0.10%
Percentage of members with a positive social determinants of health assessment	69.95%	73.04%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	79.77%	89.39%	95.72%

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

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Managed Care Operational Survey

Table 84: Aetna's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 85: Aetna's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Aetna failed to provide evidence that credentialing and re-credentialing are performed for participating providers.	Managed Long Term Care Partial Capitation Contract Article VII Section C.2 (a)	438.214
Aetna failed to provide evidence that monitoring of providers is performed for fiscal intermediaries.	Managed Long Term Care Partial Capitation Contract Article VII Section C. 1	438.214
Nine records submitted for review contained an incomplete enrollment agreement that either did not include the proposed date of enrollment or was not signed by the enrollee/representative.	Managed Long Term Care Partial Capitation Contract Article V C. 1 Article V H. 5	438.242
Of the 50 records submitted for review, 15 contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care.	Managed Long Term Care Partial Capitation Contract Article V J. 1	438.208
For nine prior authorization or concurrent reviews following a service request, no evidence was provided that Aetna either notified the enrollee of the decision in writing or that the	Managed Long Term Care Partial Capitation Contract Appendix K	438.210

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
decision was sent within the required timeframe.		
For four appeals of decisions resulting from a concurrent review, no evidence was provided that Aetna treated the appeal as an expedited review and the determination was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
Eight records with an identified disenrollment did not include evidence that either Aetna provided written notice of the intent to disenroll prior to their disenrollment, or that the intent notice did not include the proposed disenrollment date.	Managed Long Term Care Partial Capitation Contract Article V D.1.a Article V D.1.e	438.210

Focused Survey

Table 86: Aetna's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Aetna failed to consistently respond to service authorization requests within the required timeframe. **Deficiency 2:** Aetna failed to consistently respond to internal appeal requests within the required timeframe.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 87: Aetna's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Aetna's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
	All four performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Five performance measure rates calculated by the Department of Health for Aetna for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Aetna was in compliance with ten standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Aetna was not in full compliance with four standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Aetna was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Aetna should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Aetna should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Aetna should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal	Aetna should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Managed Care Standards	compliance findings. Aetna should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 88: AgeWell's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	AgeWell's Response	IPRO's Assessment of AgeWell's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, AgeWell should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	AgeWell decreased their readmission rate from 18.4 in 2021 to 13.1 in 2022. AgeWell had a transitions care manager overseeing each hospital admission, offering support to the members and their families, ensuring the member was seen by their doctors within 30 days of discharge, and monitoring medication reconciliation follow-up. The transitions care manager provided education on diagnoses management and collaborated with the team on authorizing necessary services that could prevent readmission.	Addressed.
Validation of Performance Measures		
AgeWell should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. AgeWell should also consider how to maximize realized positive outcomes of the assessment moratorium.	AgeWell continues to perform member outreach at a minimum of one outreach per month to conduct assessments, engage with members, and to identify health risks or potential hospital admission risks. The community health assessment is consistently being utilized post-hospitalization, and face-to-face assessments are conducted in the members' homes every six months. A high-risk workgroup committee was developed to meet twice per month to discuss improvement on high-risk members.	Partially addressed.
Review of Compliance with Medicaid Standards		
AgeWell should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the	AgeWell administers trainings to staff to better prepare for the compliance review. Internal audits are also conducted and guidelines are reviewed for federal and state Medicaid standards to ensure AgeWell is doing its part in following regulations.	Partially addressed.

2021 External Quality Review Recommendation	AgeWell's Response	IPRO's Assessment of AgeWell's Response
compliance review conducted by the Department of Health.		
Administration of Quality-of-Care Surveys – Member Experience		
AgeWell should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	AgeWell conducted mock surveys mailed to members to identify improvement areas in measures of satisfaction. AgeWell also mailed newsletters to members highlighting satisfaction measures and education on the significance of understanding each measure. AgeWell developed a managed long-term care work group committee to discuss quality-of-care satisfaction measures. This committee discussed initiatives, including updating assessments and conducting call center audits aimed to eliminate member confusion on any component.	Partially addressed.

Table 89: AgeWell's Performance Improvement Project Summary, 2022

AgeWell's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ AgeWell aims to increase the social determinants of health screening rate of new enrollees within the first 30 days of enrollment. ▪ AgeWell aims to reduce the positive social determinants of health screening rate through quarterly social determinants of health assessments to follow-up on members' response to clinical and non-clinical interventions. ▪ AgeWell aims to increase the social determinants of health screening rate to identify social determinants of health issues among members. ▪ AgeWell aims to reduce positive social determinants of health among members with a positive social determinants of health screen. ▪ AgeWell aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted to reduce the rate of members with a positive social determinants of health screen and perform appropriate referrals and interventions. Managed Care Plan-Focused 2022 Interventions ▪ Developed and implemented a stand-alone social determinants of health assessment modeled after the Centers for Medicare and Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool. ▪ Created a tracking and reporting tool for identifying social determinants of health needs for members to initiate referrals, as well as a process for following up on referrals. ▪ Assembled a directory of community resources for members, which are available on the plan's website and distributed in member newsletters. ▪ Trained care managers on available community-based resources to help direct members with social determinants of health issues.

Table 90: AgeWell's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	57.47%	40.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	65.18%	20.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	64.93%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	3.20%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	33.18%	30.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 91: AgeWell's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** AgeWell failed to consistently send out the evidence packets within 10 business days of the Fair Hearing notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 92: AgeWell's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	AgeWell's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Four performance measure rates calculated by the Department of Health for AgeWell for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for AgeWell for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	AgeWell was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, AgeWell should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	AgeWell should utilize the findings from the Department of Health's analysis of health	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, AgeWell should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	AgeWell should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 93: ArchCare's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	ArchCare's Response	IPRO's Assessment of ArchCare's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, ArchCare should continue to monitor member utilization and promote use of appropriate settings of care.	ArchCare reviews and monitors daily clinical alert reports and educates members on disease management, appropriate use of urgent care and primary care provider follow-up, and early identification of symptoms to prevent hospitalization. ArchCare reviews and promotes member plans of care and holds weekly care management meetings in conjunction with the medical director for review of medically complex cases. Ongoing timely care coordination is conducted to facilitate appropriate use of services.	Partially addressed.
Validation of Performance Measures		
ArchCare should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. ArchCare should also consider how to maximize realized positive outcomes of the assessment moratorium.	Internal interdepartmental collaboration enhanced ArchCare's proficiency and efficiency. Telephonic care coordination was continued and outreach was conducted for all members to ensure members' needs were met and safety was maintained. Ongoing timely care coordination and care plan development was continued with member self-reporting. ArchCare did not stop, reduce, or suspend authorized services in place during the moratorium.	Addressed.
Review of Compliance with Medicaid Standards		
ArchCare should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. ArchCare should conduct internal reviews as it prepares for the compliance review	ArchCare implemented a corrective action plan with interdisciplinary departments to address each identified deficiency. This includes ongoing monthly chart audits; timely review and response of service requests; quarterly tracking of appeals and grievance compliance rates; and conducting quarterly compliance meetings and corrective action plan trainings.	Partially addressed.

2021 External Quality Review Recommendation	ArchCare's Response	IPRO's Assessment of ArchCare's Response
conducted by the Department of Health.		
Administration of Quality-of-Care Surveys – Member Experience		
ArchCare should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	ArchCare improves rates of care management member monthly contact to develop person-centered service plans and social determinants of health assessments; ArchCare helps empower members to drive their care and improve outcomes. ArchCare continues to educate members on plan benefits and the service request process. ArchCare conducts quarterly Member Advisory Council meetings to collect feedback and address member concerns for plan improvement.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 94: ArchCare's Performance Improvement Project Summary, 2022

ArchCare's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ ArchCare aims to increase screening and follow-up related to social determinants of health disparities for all active, community-based managed long-term care members. Managed Care Plan-Focused 2022 Interventions ▪ Conducted quarterly training to educate staff regarding the prevalence and health impacts of social determinants of health. ▪ Created a process for system-generated reports to allow care managers to view member screenings for social determinants of health within the past month. ▪ Implemented a monthly review by clinical managers on 5% of positive social determinants of health screenings to validate appropriate intervention selection.

Table 95: ArchCare's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	45.45%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	83.04%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	53.47%	70.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	13.86%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	64.89%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Table 96: ArchCare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2019-2020
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	NC
438.230: Subcontractual Relationships and Delegation	NC
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 97: ArchCare's Compliance Review Summary of Results, 2019-2020

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Current person-centered service plans on record lacked member specific detail and did not consistently indicate the scope of services or include all authorized services.	Managed Long Term Care Partial Capitation Contract Article V Section J. 1 Article V J. 9. c. v.	438.208
Of the 13 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, 11 records did not contain current physician orders.	Managed Long Term Care Partial Capitation Contract Title 18	438.208
Thirty records submitted for review contain care management notes that were not sufficiently detailed to demonstrate appropriate follow up and coordination of care. In addition, care management notes did not consistently reflect updated changes to member's status each month.	Managed Long Term Care Partial Capitation Contract Article V Section J. 1	438.208
Eleven records submitted for review lacked documented evidence of a care management home visit.	Managed Long Term Care Partial Capitation Contract	438.208

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
	Article V Section J. 5.b	
For six complaints that could not be resolved immediately, no evidence was provided that the enrollee was sent acknowledgment and or resolution notices.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228
Extensions notices lacked specific info needed by ArchCare to make determination; failed to give appropriate reason for the delay and how the delay is in the best interest of the enrollee.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228
For 70 prior authorizations and concurrent reviews following a service request, no evidence was provided that ArchCare either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe; ArchCare did not provide any evidence of a Department of Health-approved approval determination template notice.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
For 12 prior authorization requests and 23 concurrent reviews requests, the time between when ArchCare's determination decision was made and when the determination notice was sent to the member was not within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
Ten decisions pertaining to a reduction did not identify the particular change in medical condition, mental condition, or social circumstance that supports the reduction, the rationales lack member-specific detail.	Managed Long Term Care Partial Capitation Contract Policy 16.06	438.210
For 28 appeals of decisions, no evidence was provided that ArchCare sent the determination within the required timeframe; ArchCare did not consistently handle appeals of concurrent reviews as expedited.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228
ArchCare failed to provide evidence that monitoring of providers is performed for fiscal intermediaries.	Managed Long Term Care Partial Capitation Contract Article VII Section A.1, C.1	438.214, 438.230
ArchCare failed to complete background checks on all personnel.	Managed Long Term Care Partial Capitation Contract Article VI C.1, VIII P iii. (A, C, D)	438.214
Five records submitted for review contain an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment or did not contain the proposed date of enrollment.	Managed Long Term Care Partial Capitation Contract Article V Section C. 1	438.242
Three records submitted for review lacked timely reassessment during the review period.	Managed Long Term Care Partial Capitation Contract Article V Section H. 5	438.208

Focused Survey

Table 98: ArchCare's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 99: ArchCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ArchCare's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for ArchCare for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	During the 2019-2020 review, ArchCare was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	ArchCare was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019-2020 review, ArchCare was not in full compliance with six standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ArchCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	ArchCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ArchCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	ArchCare should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. ArchCare should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 100: Centers Plan's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Centers Plan's Response	IPRO's Assessment of Centers Plan's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Centers Plan should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Centers Plan has continued the Transition of Care project in recognition that a safe care transition from inpatient to the community setting is essential to ensure high-quality patient care and reduce avoidable readmissions. Centers Plan discusses the project at Member Advisory Committee meetings and have received positive feedback on the project. Centers Plan's annual internal managed long-term care member satisfaction survey contains questions regarding the Transition of Care program to elicit member feedback. The results indicate positive feedback on engagement and assistance post-inpatient discharge.	Partially addressed.
Validation of Performance Measures		
Centers Plan should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Centers Plan should also consider how to maximize realized positive outcomes of the assessment moratorium.	Centers Plan quickly implemented several changes to ensure continued support of its members, including: ▪ COVID-19 education to identify any potential risks or impact to members. ▪ Review of services to ensure each member was receiving authorized services and was safe in the community. ▪ Focus on telehealth provider visits, which was a strong mitigating factor in decreasing the potential negative outcomes of the face-to-face assessment suspension. The flexibility to complete assessments via telehealth continues to remain advantageous to Centers Plan's membership today.	Partially addressed.
Review of Compliance with Medicaid Standards		
Centers Plan should execute the approved corrective action plan and conduct routine monitoring to ensure	As outlined in the Department of Health 2021 Survey Statement of Deficiencies, there were 7 areas that were found to be in need of correction. Some of the deficiencies identified were isolated incidents of non-compliance or were findings	Partially addressed.

2021 External Quality Review Recommendation	Centers Plan's Response	IPRO's Assessment of Centers Plan's Response
compliance is achieved and maintained.	relevant to historical plan processes that had been addressed prior to the survey findings. However, in order to ensure ongoing compliance, Centers Plan has executed the state approved plan of correction and continues to conduct routine monitoring to ensure compliance is achieved and maintained.	
Administration of Quality-of-Care Surveys – Member Experience		
Centers Plan should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Centers Plan works to improve member satisfaction with transportation services through: ▪ Monitoring metrics and conducting audits to hold providers accountable and enhance efficiency. ▪ Providing clear member education on accessing transportation benefits. ▪ Conducting an annual member satisfaction survey to gather member feedback. ▪ Regularly reviewing service availability and expanding as needed to meet managed long-term care members' needs.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 101: Centers Plan's Performance Improvement Project Summary, 2022

Centers Plan's Partial Capitation Performance Improvement Project Summary
Title: Searching for Health Equity through Identification of Social Determinants of Health **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Centers Plan aims to complete a social determinants of health assessment for new and continuing enrollees, and improve the documentation of referrals and follow-up made for members at-risk for social determinants of health needs. Managed Care Plan-Focused 2022 Interventions ▪ Conducted care management training for all staff. ▪ Integrated an evidence-based social determinants of health assessment tool and referrals into Centers Plan's care management platform. ▪ Enhanced the care management system with automated reports to track social determinants of health assessment indicators. ▪ Created a comprehensive referral list for care management use based on social determinants of health needs.

Table 102: Centers Plan's Managed Long-Term Care Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	94.36%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	96.84%	25.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	50.60%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.71%	Target Not Established
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	83.34%	45.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Table 103: Centers Plan's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	C
438.210: Coverage and Authorization of Services	C
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	NC
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 104: Centers Plan's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Centers Plan failed to provide evidence of appropriate credentialing to confirm qualifications and complete background checks for all personnel.	Managed Long Term Care Partial Capitation Contract Article V Section J. 2, 5(g)	438.214
Centers Plan failed to provide evidence that credentialing and re-credentialing are performed on participating providers.	Managed Long Term Care Partial Capitation Contract Article VII Section C. 1	438.214
Two records submitted for review did not include a completed enrollment agreement.	Managed Long Term Care Partial Capitation Contract Article V H.5	438.242
One record did not contain an acknowledgement or determination notice to enrollee for a grievance that could not be resolved immediately.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228

Focused Survey

Table 105: Centers Plan's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Centers Plan failed to consistently respond to internal appeal requests within the required timeframe. **Deficiency 2:** Centers Plan failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 106: Centers Plan's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Centers Plan's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Centers Plan for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Centers Plan was in compliance with eleven standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Centers Plan for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Centers Plan was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Centers Plan was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Centers Plan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Centers Plan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Centers Plan should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Centers Plan should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Centers Plan should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 107: Elderplan's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Elderplan's Response	IPRO's Assessment of Elderplan's Response
Validation of Performance Improvement Projects		
As Elderplan was not able to collect data from the intended source for the *Potentially Avoidable Hospitalizations* indicator, Elderplan should evaluate its access to alternative data sources that may allow Elderplan to determine current performance, establish a meaningful target rate, and monitor progress towards improvement.	Although Elderplan encountered data retrieval issues with the health information exchange, Elderplan's Discharge Planning Team has processes in place to ensure a safe discharge to home while notifying providers of discharges. Elderplan's Post-Acute Transition Team ensures that the services are meeting the member's post-acute needs. Through this process, Elderplan can collect hospital performance data, monitor progress against their established target rate, and implement appropriate interventions accordingly.	Partially addressed.
Validation of Performance Measures		
Elderplan should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Elderplan should also consider how to maximize realized positive outcomes of the assessment moratorium.	Elderplan did not observe negative health outcomes as a result of the moratorium. Elderplan's Interdisciplinary Team conducted frequent outreach to members to identify any changes in health status and to ensure continuity of services. Personal protective equipment was also provided. If a change in status was identified, a Uniform Assessment System for New York assessment was conducted, including via telehealth. Telehealth assessments are still being conducted if elected by a member and deemed appropriate by Elderplan.	Partially addressed.
Review of Compliance with Medicaid Standards		
Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Elderplan conducts routine monitoring, focusing on member impact whilst keeping operational documentation and processes up to date with requirements. Main risk topics include enrollment, care management, pre/post-service requests, appeals and grievances, network, contracting, pharmacy benefits/drug management program, quality improvement, marketing materials, vendor oversight, fraud waste and abuse, and compliance.	Partially addressed.

2021 External Quality Review Recommendation	Elderplan's Response	IPRO's Assessment of Elderplan's Response
	Elderplan successfully passed the Department of Health Article 44 Survey for 2021 activity.	
Administration of Quality-of-Care Surveys – Member Experience		
Elderplan should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Elderplan conducts an annual advance directive mailing to their entire membership in the member's primary language, with a copy of a blank advance directive enclosed in the mailing. Care managers (CM) address the advance directive topic with every care planning call and encourage members to complete and submit a copy of the form to Elderplan. Assessment nurses address advance directives upon completion of each Uniform Assessment System for New York assessment, providing education and offering members/caregivers assistance to complete the advance directive form at the visit. Completed forms from care managers and assessment nurses are attached within the care management system.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 108: Elderplan's Performance Improvement Project Summary, 2022

Elderplan's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Elderplan aims to increase the percentage of members with social determinants of health assessments among new and continuously enrolled members. Member-Focused 2022 Interventions ▪ Developed individualized care plans with targeted interventions for members with needs by the social determinants of health tool. Managed Care Plan-Focused 2022 Interventions ▪ Enhanced annual training program to include social determinants of health tool and available community resources. ▪ Updated workflow to include requirement to complete social determinants of health screening tool at least once a year.

Table 109: Elderplan's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	98.27%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	99.45%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	8.97%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	62.29%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 110: Elderplan's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Elderplan failed to consistently send out the evidence packets within 10 business days of the Fair Hearing notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 111: Elderplan's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderplan's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Elderplan for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Elderplan for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	Elderplan was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Elderplan should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Elderplan should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderplan should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderplan should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 112: Elderwood's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Elderwood's Response	IPRO's Assessment of Elderwood's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Elderwood should continue to monitor member utilization and promote use of appropriate settings of care.	Elderwood reviews a daily report of all emergency department visits and hospitalizations. During this review, Elderwood care managers follow-up with the members, discharge planners, and other medical personnel directly involved with the member's care to verify the stability of the patient. In addition, Elderwood's Utilization Management Department follows these members to substantiate all hours authorized.	Partially addressed.
Validation of Performance Measures		
Elderwood should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Elderwood should also consider how to maximize realized positive outcomes of the assessment moratorium.	Elderwood has reaffirmed the importance of in-person community health reassessments. With this, Elderwood has both social workers and registered nurses visiting the members yearly. This gives Elderwood's members a holistic view of their care. This gives Elderwood staff the ability to focus on the specificity of their needs and maximize positive outcomes in person immediately.	Partially addressed.
Review of Compliance with Medicaid Standards		
Elderwood should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Elderwood care management meets monthly to review various audits that are conducted to confirm the compliance of their organization. In addition, Elderwood's medical director oversees the review of policies and procedures to make sure not only is Elderwood following these policies and procedures but updating the policies and procedures to better align with current workflows.	Partially addressed.

2021 External Quality Review Recommendation	Elderwood's Response	IPRO's Assessment of Elderwood's Response
Administration of Quality-of-Care Surveys – Member Experience		
Elderwood should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Elderwood's Utilization Management and Quality Department conducts direct outreaches to members monthly in addressing the member satisfaction measures. Furthermore, if Elderwood receives a negative response from the member, either the care manager or the manager of clinical operations will personally address the response with the member in attempt to rectify and obtain better satisfaction outcomes.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 113: Elderwood's Performance Improvement Project Summary, 2022

Elderwood's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Elderwood aims to improve screening rates and follow-up for social determinants of health needs identified for their membership using clinical and non-clinical interventions. Managed Care Plan-Focused 2022 Interventions ▪ Trained social workers on prevalence and health impacts of social determinants of health, particularly among the managed long-term care population, and how to utilize the "Tools for Action" on the Healthy People 2030 website. ▪ Created new workflows to upload social determinants of health screening forms and track interventions. ▪ Held bi-weekly meetings with care management system vendor to support tracking initiatives to improve efficiencies of data collection and accurate report delivery as social determinants of health data migrates from spreadsheet tracking to the care management system.

Table 114: Elderwood's Performance Improvement Project Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	81.04%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	83.17%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	12.14%	20.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	32.42%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	30.77%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 115: Elderwood's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 116: Elderwood's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderwood's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	Elderwood was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Five performance measure rates calculated by the Department of Health for Elderwood for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Recommendations				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	In the ongoing performance improvement project, Elderwood should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Elderwood should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Elderwood should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Elderwood should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 117: Empire BCBS HealthPlus's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Empire BCBS HealthPlus should strive to decrease avoidable readmissions.	In 2021, Empire BCBS HealthPlus's performance improvement plan topic was on emergency room visits/hospitalization reduction. In 2023, there was a resubmission of Empire BCBS HealthPlus's 2021 data, which showed Empire BCBS HealthPlus meeting its targeted goals. Integra has merged with Empire BCBS HealthPlus's managed long-term care plan, who has now adopted the prior Integra Transition of Care performance improvement project. The readmission rate for quarter 2 of 2023 was 14.65, with June at 10.67. Empire BCBS HealthPlus will continue to monitor.	Addressed.
Validation of Performance Measures		
Empire BCBS HealthPlus should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Empire BCBS HealthPlus should also consider how to maximize realized positive outcomes of the assessment moratorium.	Empire BCBS HealthPlus members were contacted monthly to assess their needs and safety in the community. If a member requested a change in their plan of care, the care manager collaborated with the member's community health team for updated information on the member. Empire BCBS HealthPlus utilized the medical director rounds to discuss cases and did not find a negative impact from the moratorium. Currently, Integra is now Empire BCBS HealthPlus, and they are doing Uniform Assessment System for New York assessments via telehealth and in-person assessments.	Addressed.
Review of Compliance with Medicaid Standards		
Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the	Empire BCBS HealthPlus had no Department of Health audits during 2022. Empire BCBS HealthPlus did conduct internal audits and monitoring of areas of contractual compliance. These findings were reported at quarterly Quality Committee meetings. Opportunities for improvement were identified and plans for improvement were presented. The	Partially addressed.

2021 External Quality Review Recommendation	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
compliance review conducted by the Department of Health.	committee membership shared recommendations on strategies for improvement.	
Administration of Quality-of-Care Surveys – Member Experience		
Empire BCBS HealthPlus should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Empire BCBS HealthPlus implemented performance improvement strategies to improve its member satisfaction measures. The areas of focus were the Rating of Health Plan measure, dental measures, home health aide measures, and the Appointing for Health Decisions measures. Empire BCBS HealthPlus utilized an internal member satisfaction survey that was sent to members bi-annually. The objective of the survey was to obtain "real-time" data from members on areas that needed improvement. Empire BCBS HealthPlus established a Member Engagement Committee to develop improvement strategies.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 118: Empire BCBS HealthPlus's Performance Improvement Project Summary, 2022

Empire BCBS HealthPlus's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Empire BCBS HealthPlus aims to increase the percentage of completed social determinants of health screenings and interventions for managed long-term care and fully integrated dual eligible members. Member-Focused 2022 Intervention ▪ Developed and distributed education materials and social determinants of health toolkits for member communication that include local resources and available programs related to social determinants of health. Managed Care Plan-Focused 2022 Interventions ▪ Educated staff on the prevalence and health impacts of social determinants of health among the managed long-term care population. ▪ Created system-generated reports to allow care managers to monitor and track identified social determinants of health needs and interventions. ▪ Trained care management staff on the social determinants of health screening tool and tracking interventions. ▪ Educated managed long-term care service providers (licensed home care services agencies) on social determinants of health needs and health plan's interventions.

Table 119: Empire BCBS HealthPlus's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	50.78%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	53.14%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	57.33%	10.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	7.12%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	73.82%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 120: Empire BCBS HealthPlus's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 121: Empire BCBS HealthPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Empire BCBS HealthPlus's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	All performance measure rates calculated by the Department of Health for Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Empire BCBS HealthPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Empire BCBS HealthPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assurance and performance improvement program.			
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 122: EverCare's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	EverCare's Response	IPRO's Assessment of EverCare's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, EverCare should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	EverCare's Transition of Care Program manages all care transitions. The program is led by the transition of care nurse, whose sole responsibility is to support members who have been admitted or recently discharged. The transition of care nurse follows members from admission, during discharge planning, and post-hospitalization in the community. Standardized education and assessments are in place to ensure a smooth transition home with appropriate services in place, as well as to prevent avoidable readmission.	Partially addressed.
Validation of Performance Measures		
EverCare should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. EverCare should also consider how to maximize realized positive outcomes of the assessment moratorium.	EverCare mitigated potential negative member health impacts from the moratorium. In immediate response, EverCare implemented processes to enhance the collaboration between EverCare's Care Management Department and their Utilization Management Department to ensure sound clinical judgement was used to address the membership's unique and changing needs during the height of the COVID-19 pandemic. EverCare continues to capitalize on the establishment of virtual care models during the COVID-19 pandemic to continue to meet the needs and preferences of their membership.	Partially addressed.
Review of Compliance with Medicaid Standards		
EverCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	An interdisciplinary approach is used to ensure compliance with Medicaid standards. Routine and targeted audits are conducted by EverCare's Compliance Department, their Learning and Organizational Effectiveness Department, and EverCare's management, to track compliance, to lead to the early identification of potential issues, to quickly identify root causes, and to ensure a	Partially addressed.

2021 External Quality Review Recommendation	EverCare's Response	IPRO's Assessment of EverCare's Response
	collaborative approach to remediation. Both EverCare's Quality and Compliance Committees follow identified issues to ensure remedial measures attain and maintain desired results.	
Administration of Quality-of-Care Surveys – Member Experience		
EverCare should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	EverCare met or exceeded 12 of 16 measures. Two (2) unmet measures were related to EverCare's dental carrier, who has been replaced. Measures are in place to monitor for continued improvement. A third measure was related to EverCare's regular visiting nurse. EverCare has established regular case conferences with key home care providers to ensure identification and resolution of issues. The fourth issue was related to the management of illness. EverCare has implemented a disease management educational program with their care management team.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 123: EverCare's Performance Improvement Project Summary, 2022

EverCare's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ EverCare aims to improve the rate of completed stand-alone social determinants of health assessments for newly enrolled members. ▪ EverCare aims to improve the rate of completed stand-alone social determinants of health assessments for continuously enrolled members. ▪ EverCare aims to increase the rate of care manager contacts where a screen for social determinants of health is conducted for all members. ▪ EverCare aims to improve the identification of members with social determinants of health needs. ▪ EverCare aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ EverCare aims to increase the percentage of members identified with a positive social determinants of health assessment and have documented interventions to address need(s). Member-Focused 2022 Interventions ▪ Monitored status of referrals and receipt of service with non-contracted community-based organizations via monthly call with referred member. ▪ Developed new member educational materials to include information about available programs and benefits related to social determinants of health. Provider-Focused 2022 Interventions ▪ Educated value-based payment homecare providers on social determinants of health. Managed Care Plan-Focused 2022 Interventions ▪ Trained care managers on social determinants of health including appropriate implications, screening tools, community organizations/resources, covered benefits, prevalence, and health impacts of social determinants of health among the managed long-term care population. ▪ Embedded social determinants of health screening into electronic medical records. ▪ Established protocols to ensure social determinants of health screening occurs at least every six months. ▪ Monitored status of referrals and receipt of service with contracted community-based organizations via monthly case conferencing with community-based organizations. ▪ Developed a workflow to monitor and track members with social determinants of health needs by ensuring closed-loop referrals to community services and supports.

Table 124: EverCare Choice's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	66.45%	75.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	98.35%	98.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	80.57%	80.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	13.24%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	54.70%	70.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Managed Care Operational Survey

Table 125: EverCare's Compliance with Federal Standards Results

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	NC
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	C
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

Table 126: EverCare's Compliance Review Summary of Results, 2021-2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Nine records submitted for review contain an incomplete enrollment agreement that did not contain the proposed date of enrollment.	Managed Long Term Care Partial Capitation Contract Article V C. 1 Article V H. 5	438.242
The majority of person-centered service plans on record did not consistently indicate the scope of services.	Managed Long Term Care Partial Capitation Contract Article V J.1 Article V J.9.c.vii	438.208
Four records submitted for review did not contain an accurate written back-up plan.	Managed Long Term Care Partial Capitation Contract Article V J. 9. C. vi	438.208
For eight prior authorization and concurrent reviews following a service request, no evidence was provided that EverCare either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.	Managed Long Term Care Contract Appendix K	438.210
For two appeals of initial service request determinations, no evidence was provided that the appeal determination was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
For seven initial adverse determination notices sent as the result of a termination, reduction, or suspension, no evidence was provided that Evercare notified the enrollee in writing of the intended action. In four cases, an approval was inaccurately sent for a member-requested action.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
Three records did not contain required model determination notice to enrollee for a complaint that could not be resolved immediately, and failed to provide Notice of Non-Discrimination to enrollee.	Managed Long Term Care Partial Capitation Contract Article II.H.	438.100

Focused Survey

Table 127: EverCare's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** EverCare failed to consistently treat appeals of concurrent reviews as expedited, and responding within the required timeframe. **Deficiency 2:** EverCare failed to consistently send out the evidence packet within the required timeframe, resulting in a member's fair hearing being rescheduled.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 128: EverCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	EverCare's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021-2022 review, EverCare was in compliance with ten standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Two performance measure rates calculated by the Department of Health for EverCare for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	During the 2021-2022 review, EverCare was not in full compliance with four standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	EverCare was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, EverCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	EverCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, EverCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Ever Care should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2021-2022 compliance findings. Ever Care should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 129: Extended MLTC's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Extended MLTC's Response	IPRO's Assessment of Extended MLTC's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Extended MLTC should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Extended MLTC exited the Partial Capitation program as of August 1, 2023, and was not available to respond to the 2021 recommendations.	Unable to assess the Managed Long-Term Care plan's response due to the availability of limited information.
Validation of Performance Measures		
Extended MLTC should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Extended MLTC should also consider how to maximize realized positive outcomes of the assessment moratorium.	Extended MLTC exited the Partial Capitation program as of August 1, 2023, and was not available to respond to the 2021 recommendations.	Addressed.
Review of Compliance with Medicaid Standards		
Extended MLTC should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Extended MLTC exited the Partial Capitation program as of August 1, 2023, and was not available to respond to the 2021 recommendations.	Unable to assess the Managed Long-Term Care plan's response due to the availability of limited information.
Administration of Quality-of-Care Surveys – Member Experience		
Extended MLTC should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Extended MLTC exited the Partial Capitation program as of August 1, 2023, and was not available to respond to the 2021 recommendations.	Unable to assess the Managed Long-Term Care plan's response due to the availability of limited information.

Performance Improvement Project Summary and Results, 2022

Table 130: Extended MLTC's Performance Improvement Project Summary, 2022

Extended MLTC's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Extended MLTC aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Extended MLTC aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Extended MLTC aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Extended MLTC aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ Extended MLTC aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). Member-Focused 2022 Intervention ▪ Developed and distributed member education materials which included information about available programs and health plan benefits related to social determinants of health. Managed Care Plan-Focused 2022 Interventions ▪ Trained care management staff regarding the prevalence and health impacts of social determinants of health among the managed long-term care population, screening process, and recommended interventions to address five social determinants of health domains. ▪ Created a new electronic note type for documentation of positive social determinants of health findings in the care management record. ▪ Developed a social determinants of health workflow to ensure closed-loop process for implementation of planned care management interventions for all positive social determinants of health findings.

Table 131: Extended MLTC's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	92.00%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	94.50%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	47.82%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	4.56%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Survey

Table 132: Extended MLTC's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 133: Extended MLTC's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Extended MLTC's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Extended MLTC for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	Extended MLTC was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Extended MLTC should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Extended MLTC should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Extended MLTC should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Extended MLTC should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 134: Fallon Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Fallon Health's Response	IPRO's Assessment of Fallon Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Fallon Health should continue to monitor member utilization and promote use of appropriate settings of care. To ensure future performance improvement project methodologies are effectively designed and managed, Managed Long-Term Care Plan staff should complete performance improvement project refresher trainings, consult the Centers for Medicare & Medicaid Services protocol to ensure the performance improvement project meets all validation requirements, and fully address issues identified by the external quality review organization during the proposal phase, interim reporting phase, and final reporting phase.	Fallon Health has continued to monitor members monthly for primary care provider involvement and linkage with a new primary care provider, when identified as a need in the electronic medical record. Fallon Health has continued to monitor emergency department utilization/hospitalizations and educate members on appropriate use of hospital utilization versus a primary care provider visit need as identified by the regional health information organization or in the electronic medical record or a phone call to a primary care provider's office to discuss use of an emergency department/hospital versus a primary care provider visit when identified as a need in electronic medical record reporting.	Partially addressed.
Validation of Performance Measures		

2021 External Quality Review Recommendation	Fallon Health's Response	IPRO's Assessment of Fallon Health's Response
Fallon Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Fallon Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	The community health reassessment moratorium negative impact of health of members with access to timely care and staffing was reviewed and monitored. Staffing was reviewed and increased to improve timely care in addressing the needs of members and coordination of care.	Partially addressed.
Review of Compliance with Medicaid Standards		
Fallon Health should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Fallon Health has implemented the corrective action plan with monthly and quarterly monitoring as indicated. All items are monitored and managed by Fallon Health's program director to meet requirements.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
Fallon Health should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Quality monitoring of providers and their services, as well as representation to members has been implemented. Fallon Health's provider availability has been reviewed and an update was provided to members; documentation of review is in the electronic medical record to support. Fallon Health's transportation provider continues to show concern from internal auditing of quality due to this provider's reporting and lack of available staffing during times of need. Provider contracts have been reviewed in process to ensure enough providers are available for members.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 135: Fallon Health's Performance Improvement Project Summary, 2022

Fallon Health's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Fallon Health aims to increase screening rates, and follow-up for social determinants of health needs among managed long-term care members using clinical and non-clinical interventions. Managed Care Plan-Focused 2022 Interventions ▪ Integrated an electronic medical record-generated report to identify members in need of a social determinants of health assessment.

Table 136: Fallon Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	97.70%	97.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	99.63%	97.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	50.26%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	58.22%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Table 137: Fallon Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 138: Fallon Health's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Fallon Health failed to provide evidence of Board level accountability for overall oversight of program activities and review and approval of the quality assurance and performance improvement program.	Managed Long Term Care Contract, Article V Section F.1(a) Regulation Title 10 NYCRR Section 98-1. (f) (1) (iii)	438.242
Fallon Health did not provide sufficient evidence that the quality committee met four times 2020 and 2021.	Managed Long Term Care Contract, Article V Section F.1(a) Regulation Title 10 NYCRR Section 98-1. (f) (1) (iii)	438.242
Fallon Health failed to provide evidence that credentialing and re-credentialing is performed on participating providers on a periodic basis (initially and not less than once every three years) and for monitoring provider performance.	Managed Long Term Care Contract Article VII Section C. 1	438.214

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Fallon Health failed to provide evidence of appropriate credentialing to confirm qualifications and complete background checks for all personnel.	Managed Long Term Care Contract Article V Section J. 2, 5(g)	438.214
Fallon Health failed to provide evidence that monitoring of providers is performed for fiscal intermediaries.	Managed Long Term Care Contract Article V11 Section A.1, VII Section C. 1	438.206
Three records pertaining to non-dual enrollees contained documentation that indicated the non-dual enrollees were not consistently assessed as eligible for nursing home level of care and therefore do not meet the criteria for participation in a Managed Long Term Care partial capitation plan.	Managed Long Term Care Partial Capitation Contract Article V D.4.f	438.210
One record submitted for review contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment.	Managed Long Term Care Partial Capitation Contract Article V C.1, Article V H.5	438.242
The majority of person centered service plans on record did not consistently indicate the scope, duration, and/or frequency of covered services, or were not documented in an easily understood format.	Managed Long Term Care Partial Capitation Contract Article V J.1, Article V J.9.c.vii	438.208
Seven records submitted for review did not contain a written back-up plan or the back-up plan was incomplete.	Managed Long Term Care Partial Capitation Contract Article V J.9.c.vi	438.208
Twenty-one records submitted for review contained care management notes that were not sufficiently detailed to demonstrate appropriate follow up and coordination of care.	Managed Long Term Care Partial Capitation Contract Article V J.1 Title 18 NYCRR Section 505.16 (c) (6)	438.208
Four records submitted for review that indicated the enrollee was receiving consumer directed personal assistance services did not contain a complete and/or appropriate physician's order.	Title 18 NYCRR Section 505.28 (d)(1)(i-iv) Section 505.28 (f)(1) Section 505.28(e)(4)	438.208
Four initial adverse determinations that were the result of a termination, reduction, or suspension did not show evidence that the notice was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210

Focused Survey

Table 139: Fallon Health's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 140: Fallon Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fallon Health's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021-2022 review, Fallon Health was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Fallon Health was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	All performance measure rates calculated by the Department of Health for Fallon Health for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2021-2022 review, Fallon Health was not in full compliance with five standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fallon Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Fallon Health should utilize the findings from the Department of Health's analysis of health	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fallon Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Fallon Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2021-2022 compliance findings. Fallon Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 141: Fidelis Care's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Fidelis Care should continue to monitor member utilization and promote use of appropriate settings of care.	Fidelis Care has continued to monitor member utilization of both emergency department and hospitalizations. Fidelis Care's care management monitors utilization through monthly calls and the regional health information organization (Healthix). Member education materials are provided to the member on utilization of the proper level of care and follow up with their primary care provider for non-emergent situations. Fidelis Care conducts monthly member record reviews to monitor utilization and care management follow-up.	Partially addressed.
Validation of Performance Measures		
Fidelis Care should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Fidelis Care should also consider how to maximize realized positive outcomes of the assessment moratorium.	The moratorium prevented managed care plans from conducting routine reassessments and in-home, face-to-face visits for approximately two years. Fidelis Care conducted telephonic assessments which were valid for 90 days and thus resulted in more frequent assessment. In March 2021, Fidelis Care conducted virtual assessments of its members in lieu of in-home visits during the COVID-19 pandemic. Fidelis Care also conducted monthly care management calls with members to review their care and provided education as needed.	Partially addressed.
Review of Compliance with Medicaid Standards		
Fidelis Care should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2018-2019 compliance findings. Fidelis Care should conduct internal reviews as it prepares for the compliance review	Fidelis Care has robust routine monitoring to ensure compliance with federal and state standards. Fidelis Care conducts semi-annual mock survey reviews of a randomized sampling of member records. Results of the mock surveys are reported to Fidelis Care's Compliance Department for review and monitoring.	Partially addressed.

2021 External Quality Review Recommendation	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
conducted by the Department of Health.		
Administration of Quality-of-Care Surveys – Member Experience		
Fidelis Care should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Fidelis Care has added member satisfaction questions to the monthly call template. All staff have gone through customer satisfaction education. Calls with members are reviewed for customer service, accuracy, and documentation. Member input regarding satisfaction is a regular part of quarterly Participant Advisory Committee meetings. Member concerns are addressed, and members are provided follow-up to address their concerns.	Partially addressed.

Table 142: Fidelis Care's Performance Improvement Project Summary, 2022

Fidelis Care's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among new enrollees within the first 30 days of enrollment. ▪ Fidelis Care aims to increase the percentage of stand-alone social determinants of health assessments among continuously enrolled members. ▪ Fidelis Care aims to increase the percentage of care manager contacts where a stand-alone social determinants of health screening was conducted. ▪ Fidelis Care aims to increase the percentage of members with documented action taken to address need(s). Member-Focused 2022 Interventions ▪ Published a member newsletter article on social determinants of health resources. ▪ Linked members identified with a positive social determinants of health assessment to appropriate resources based on member need. Managed Care Plan-Focused 2022 Interventions ▪ Updated care management workflow to include member education on the importance of completing assessments. ▪ Educated staff on the impact of social determinants of health, assessment tools, and resources available.

Table 143: Fidelis Care's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	58.39%	70.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	74.54%	70.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	84.20%	95.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	18.88%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	77.68%	30.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 144: Fidelis Care's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 145: Fidelis Care's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Fidelis Care for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	Fidelis Care was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Fidelis Care for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fidelis Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Fidelis Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fidelis Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Fidelis Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 146: Hamaspik's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Hamaspik's Response	IPRO's Assessment of Hamaspik's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Hamaspik should continue to monitor member utilization and promote use of appropriate settings of care.	Since the implementation of the performance improvement project on social determinants of health in the last quarter of 2021, Hamaspik has implemented workflows, systems of support, education, and reporting that supports the actionable utilization of the social determinants of health data, which drives initiatives and interventions to improve the access of care for Hamaspik's managed long-term care membership.	Remains an opportunity to be addressed.
Validation of Performance Measures		
Hamaspik should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Hamaspik should also consider how to maximize realized positive outcomes of the assessment moratorium.	In 2021, Hamaspik developed an alternative telephonic assessment, which was a condensed version of the Uniform Assessment System for New York assessment, to evaluate members who had a change in condition, new diagnosis, informal supports, etcetera. Hamaspik ensured continuous authorization of services, and reviewed and updated person-centered service plans for members and assessed any changes. Hamaspik also added remote support groups for members to assist them with social interaction during the COVID-19 pandemic.	Partially addressed.
Review of Compliance with Medicaid Standards		
Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Hamaspik's Compliance Department conducts a range of internal audits each month, to ensure that regulatory requirements are met. These audits include (but are not limited to) the review of enrollment and disenrollment documentation, care management activities, utilization management processes, member notices, member services, billing, and claims payment. The audit reports are reviewed during Hamaspik's Compliance Committee	Partially addressed.

2021 External Quality Review Recommendation	Hamaspik's Response	IPRO's Assessment of Hamaspik's Response
	meetings and identified areas for improvement are addressed.	
Administration of Quality-of-Care Surveys – Member Experience		
Hamaspik should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Based on the survey results, Hamaspik did not significantly vary from the program average.	Remains an opportunity to be addressed.

Performance Improvement Project Summary and Results, 2022

Table 147: Hamaspik's Performance Improvement Project Summary, 2022

Hamaspik's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for new members within the first 30 days of enrollment. ▪ Hamaspik aims to improve the rate of completed stand-alone social determinants of health assessments for members who have been continuously enrolled with the plan. ▪ Hamaspik aims to improve the rate of care manager contacts where a social determinants of health screen is conducted. ▪ Hamaspik aims to determine the percentage of members who have a positive social determinants of health assessment. ▪ Hamaspik aims to improve the rate of members with a positive social determinants of health assessment who have documented interventions to address the identified need(s). Provider-Focused 2022 Intervention ▪ Collaborated with in-network home care services agencies and primary care providers to engage members with positive social determinants of health indicators. Managed Care Plan-Focused 2022 Interventions ▪ Integrated a social determinants of health assessment tool within Hamaspik's electronic medical record system that enables direct reporting of the performance improvement project's indicators. ▪ Modified existing workflows and developed new workflows to support the social determinants of health assessment. ▪ Trained care managers on social determinants of health.

Table 148: Hamaspik's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	26.67%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	1.17%	25.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	1.03%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	25.00%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 149: Hamaspik's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 150: Hamaspik's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Hamaspik's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Hamaspik was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for Hamaspik for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Hamaspik should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Hamaspik should utilize the findings from the Department of Health's analysis of health	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Hamaspik should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 151: iCircle's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	iCircle's Response	IPRO's Assessment of iCircle's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, iCircle should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	iCircle continues to work to improve member experience during transitions of care by completing prompt follow-up and coordination of care. iCircle utilizes qualified entities, such as the regional health information organization, to obtain alerts of hospital and emergency department discharges. These alerts are uploaded to iCircle's electronic health record and assigned to a care manager for review and follow-up.	Partially addressed.
Validation of Performance Measures		
iCircle should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. iCircle should also consider how to maximize realized positive outcomes of the assessment moratorium.	The community health reassessment moratorium created a challenge in assessing a member's change in condition following hospitalizations, disease progression, new diagnoses, etcetera. However, iCircle was able to improve internal review processes and strengthen relationships with community providers and primary care providers who continued to see members in the community. Their input and documentation were invaluable to addressing members' needs and safety while the moratorium was in place.	Partially addressed.
Review of Compliance with Medicaid Standards		
iCircle should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. iCircle should conduct internal reviews as it prepares for the compliance review conducted by the	iCircle is committed to establishing and maintaining an effective compliance program, which includes an effective system for routine monitoring and auditing to identify and promptly respond to any potential risks. iCircle policies and procedures review the effectiveness of internal controls designed to ensure compliance with state and federal regulations and address areas of compliance risk. iCircle conducts monitoring and oversees corrective actions and process improvements.	Partially addressed.

2021 External Quality Review Recommendation	iCircle's Response	IPRO's Assessment of iCircle's Response
Department of Health.		
Administration of Quality-of-Care Surveys – Member Experience		
iCircle should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	In the member satisfaction portion of the Quality-of-Care survey results, iCircle scored significantly worse than other plans in talking with members about appointing for health decisions. iCircle has begun, on a quarterly basis, reviewing a member's current advance directives in place, encouraging those who do not have them in place to do so, and providing education and resources available to assist them in doing so. Care managers also collaborate with primary care providers.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 152: iCircle's Performance Improvement Project Summary, 2022

iCircle's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ iCircle aims to increase the percentage of new enrollees who undergo a stand-alone assessment for social determinants of health within 30 days of enrollment. ▪ iCircle aims to increase the percentage of continuously enrolled members who undergo at least one stand-alone assessment within the measurement year. ▪ iCircle aims to increase the percentage of quarterly routine care manager contacts where a screening was performed for social determinants of health. ▪ iCircle aims to decrease the number of members with a positive social determinants of health assessment. ▪ iCircle aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. Managed Care Plan-Focused 2022 Interventions ▪ Trained clinical staff on the five domains of social determinants of health. ▪ Integrated a social determinants of health assessment and other screening tools into the care management platform. ▪ Partnered with Find Health to refer members to an existing resource that addresses social determinants of health.

Table 153: iCircle's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	59.94%	65.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	86.50%	90.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	24.80%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	36.45%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	95.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Managed Care Operational Survey

Table 154: iCircle's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	NC
438.230: Subcontractual Relationships and Delegation	NC
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 155: iCircle's Compliance Review Summary of Results, 2019-2020

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Seven records did not include evidence that the member received a copy of their current person-centered service plan.	Managed Long Term Care Partial Capitation Contract Article V Section J. 7 Article V J. 9.c.viii	438.208
Nineteen of 50 records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and care coordination; or contained inaccurate information.	Managed Long Term Care Partial Capitation Contract Article V § J. 1	438.208
Twenty-six of 39 records that indicated that the enrollee was receiving consumer-directed personal assistance services did not contain a complete and/or updated physician's order. In addition, eight records contained physician's orders that were not submitted within 30 calendar days from the medical exam.	New York State Public Health Law Title 18	438.210
For the 58 prior authorization and concurrent reviews following a service request, no evidence was provided that iCircle either notified the enrollee of the decision in writing or that the	Managed Long Term Care Partial Capitation Contract Appendix K	438.228

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
decision was sent within the required timeframe.		
For 32 records, no evidence was provided that iCircle verbally notified the enrollee of the service request determination.	Managed Long Term Care Partial Capitation Contract Appendix K	438.214
iCircle failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.	Managed Long Term Care Partial Capitation Contract Article VII, C.1	438.230
For 11 prior authorization and concurrent reviews following a service request, iCircle inappropriately issued multiple extension notices to enrollees.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
Nine decisions pertaining to a reduction did not identify the specific change in medical condition, mental condition, or social circumstance that supported the reduction and explained why the service should be reduced as a result.	Managed Long Term Care Partial Capitation Contract Policy 16.06	438.210
One record reviewed indicated that iCircle inappropriately disenrolled a dual eligible member based on nursing home level of care score, Uniform Assessment System for New York Community Health Assessment indicated member needed 120 days of long-term care services.	Managed Long Term Care Partial Capitation Contract Article V Section D.4.f	438.210
iCircle failed to provide evidence of an executed contract that includes Social Day Care requirements.	Managed Long Term Care Partial Capitation Contract Article VII, C.2 (a)	438.206
Two records selected for review were non-dual members transferred from a mainstream Medicaid product whose documentation indicated that they did not meet the eligibility criteria for a partial capitation plan and were erroneously enrolled.	Managed Long Term Care Partial Capitation Contract Article IV A. I. b.	438.242
Of the seven records pertaining to non-dual enrollees, four contained documentation indicating that the non-dual enrollees were not consistently assessed as eligible for nursing home level of care and therefore did not meet the criteria for participation in a managed long term care partial capitation plan.	Managed Long Term Care Partial Capitation Contract Article V Section D. 4. f	438.210
Two records submitted for review were not signed by the enrollee or enrollee rep. In addition, one record contained an incomplete enrollment agreement that did not demonstrate	Managed Long Term Care Partial Capitation Contract Article V Section C. 1 Article V Section H. 5	438.242

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
that the enrollee received all materials required on enrollment.		
Current person-centered service plans on record lacked member specific detail. In addition, person centered service plans did not consistently indicate the scope of services.	Managed Long Term Care Partial Capitation Contract Article V Section J. 1 Article V J. 9. d. VII	438.208

Focused Surveys

Table 156: iCircle's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** iCircle failed to send out an evidence packet prior to fair hearing, resulting in member's fair hearing being rescheduled.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 157: iCircle's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	iCircle's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021-2022 review, iCircle was in compliance with seven standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Five performance measure rates calculated by the Department of Health for iCircle for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2021-2022 review, iCircle was not in full compliance with seven standards of *42*	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Code of Federal Regulations Part 438 Managed Care.			
	iCircle was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, iCircle should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	iCircle should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, iCircle should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	iCircle should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 158: Integra's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Integra's Response	IPRO's Assessment of Integra's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Integra should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Integra's baseline readmission rate for 2018 was 19.9%, with a goal rate of 15%. This performance improvement project is still being monitored. In order to improve a member's transition post-discharge, Integra does a post-discharge assessment within 72 hours of discharge, with a goal of 90%. In 2023, the rate of completion for the post-discharge questionnaire in April was 97%; in May, the rate was 94%, and 98% in June. The readmission rate for the second quarter of 2023 was 14.65%, with June's rate at 10.67%. Integra will continue to monitor this project.	Addressed.
Validation of Performance Measures		
Integra should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Integra should also consider how to maximize realized positive outcomes of the assessment moratorium.	Integra increased telephonic assessments by the care management team and therefore did not find a negative impact from the moratorium. Currently, Integra is now Empire BCBS HealthPlus and Uniform Assessment System for New York assessments are being conducted via telehealth and in-person assessments.	Partially addressed.
Review of Compliance with Medicaid Standards		
Integra should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2018-2019 compliance findings. Integra should conduct internal reviews as it prepares for the compliance review	Integra prepared and submitted an extensive plan of correction that was accepted by the Department of Health. All items had a monitoring plan for compliance. Ongoing monitoring continues via daily and weekly reporting, as well as monthly auditing.	Partially addressed.

2021 External Quality Review Recommendation	Integra's Response	IPRO's Assessment of Integra's Response
conducted by the Department of Health.		
Administration of Quality-of-Care Surveys – Member Experience		
Integra should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Integra received a citation for "Document appointing for Health Decisions". As per the Department of Health managed care contract, plans are not required to obtain this document from members. Integra is required to have the discussion with the member and document that discussion; Integra is in compliance with that requirement.	Remains an opportunity to be addressed.

Performance Improvement Project Summary and Results, 2022

Table 159: Integra's Performance Improvement Project Summary, 2022

Integra's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Integra aims to increase the number of continuously enrolled members screened using a stand-alone assessment for social determinants of health within 30 days of the assessment. ▪ Integra aims to increase the number of newly enrolled members enrolled members screened using a stand-alone assessment for social determinants of health within 30 days of enrollment. ▪ Integra aims to increase the percentage of members with a positive social determinants of health screen who have documented clinical and/or non-clinical interventions to address these concerns. Managed Care Plan-Focused 2022 Interventions ▪ Integrated a social determinants of health screening tool within Integra's electronic health record system. ▪ Educated care management staff on the prevalence and health impacts of social determinants of health.

Table 160: Integra's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	98.83%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	78.32%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	78.90%	10.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	4.72%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	38.18%	33.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 161: Integra's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Integra failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification, including one case that the packet was sent after the fair hearing.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 162: Integra's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Integra's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Five performance measure rates calculated by the Department of Health for Integra for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for Integra for measurement year 2022 performed statistically	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.			
Compliance with Federal Managed Care Standards	Integra was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Integra should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Integra should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Integra should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Integra should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 163: Kalos Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Kalos Health's Response	IPRO's Assessment of Kalos Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Kalos Health should continue to monitor member utilization and promote use of appropriate settings of care.	Kalos Health continues to monitor emergency room, inpatient, and potentially avoidable hospitalization encounters monthly via available health information exchange data and member disclosure. Encounter data are shared among the clinical team to identify population-level utilization trends and individual members possibly needing additional review and intervention. Kalos Health continues to deploy focused interventions for members with sepsis-risk or sepsis-related encounters.	Partially addressed.
Validation of Performance Measures		
Kalos Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Kalos Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	The moratorium understandably reduced the availability of comprehensive health data to assess population and individual levels of health status. Kalos Health maintained at least minimally sufficient insight for care management by maintaining required monthly contact with members, capturing, and reviewing health care service utilization data, and communicating with members' service providers. Tele-visit methods were defined and deployed, as able, to assist with member contact options.	Partially addressed.
Review of Compliance with Medicaid Standards		
Kalos Health should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Kalos Health includes the corrective action plan deliverables on its Quality Assurance and Process Improvement Committee quarterly agenda for status review and discussion. Additional ad hoc meetings are held to discuss any deliverables that need development or refinement to ensure	Partially addressed.

2021 External Quality Review Recommendation	Kalos Health's Response	IPRO's Assessment of Kalos Health's Response
	sufficient oversight of departmental operations and outcomes.	
Administration of Quality-of-Care Surveys – Member Experience		
Kalos Health should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Kalos Health added the under-performing member satisfaction measures to its Quality Assurance and Process Improvement Committee agenda. The Quality Assurance and Process Improvement Committee will prioritize the measures needing the most and/or urgent attention, then develop a viable internal action plan. Some topics might already be positively affected due to operational and/or resource changes in Kalos Health: an example of this is a new third-party administrator was contracted for dental services.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 164: Kalos Health's Performance Improvement Project Summary, 2022

Kalos Health's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Kalos Health aims to increase the percentage of new and continuing members who are assessed for social determinants of health risks. ▪ Kalos Health aims to ensure that members with one or more social determinants of health risks have at least one mitigating intervention implemented for each social determinant of health risk. Member-Focused 2022 Interventions ▪ Updated the care plan of members with a social determinant of health risk to reflect the identified risk and the intervention/resource applied to mitigate the risk. Managed Care Plan-Focused 2022 Interventions ▪ Finalized implementation of a digital social determinants of health assessment tool that meets the domain requirements of the performance improvement project. ▪ Updated internal operational policies and procedures to support proper completion of the social determinants of health assessment tool. ▪ Trained staff who are designated to perform social determinants of health assessments on related operational processes.

Table 165: Kalos Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	0.00%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	0.21%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	0.37%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	100.00%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Managed Care Operational Survey

Table 166: Kalos Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 167: Kalos Health's Compliance Review Summary of Results, 2021-2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Kalos Health failed to provide evidence that credentialing and re-credentialing is performed on participating providers on a periodic basis (initially and not less than once every three years) and for monitoring provider performance.	Managed Long Term Care Contract Article VII Section C. 1	438.214
Kalos Health failed to provide evidence that monitoring of providers is performed for Fiscal Intermediaries.	Managed Long Term Care Contract Article V11 Section A.1 Article VII Section C. 1	438.206
Documentation provided by the Plan identified failure to routinely comply with Kalos Health Enrollment Denial Process.	Managed Long Term Care Partial Capitation Contract Article V B.3.b Article V C.2	438.242
Three records submitted for review contain an incomplete enrollment agreement that do not demonstrate that the enrollee received all materials required on enrollment or do not contain the proposed date of enrollment.	Managed Long Term Care Partial Capitation Contact Article V H.5	438.242
The majority of person-centered service plans on record did not consistently indicate the scope, duration, and frequency	Managed Long Term Care Partial Capitation Contract	438.208

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
of services, or services were not documented in easily understood language and format.	Article V J.1 Article V J.9.c.vii	
Forty records did not contain a written back-up plan or the back-up plan was incomplete.	Managed Long Term Care Partial Capitation Contract Article V J.9.c.vi	438.208
Four records that contained initial adverse determination denial notices were not sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
For seven appeals, no evidence was provided that Kalos Health notified the enrollee of the decision in writing or that the determination was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
Seven Final Adverse Determination notices on file, where the denial was based on medical necessity, did not contain evidence that the external appeal application was attached to the notice.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
One record that indicated the enrollee was involuntarily disenrolled did not include evidence that Kalos Health provided the proposed disenrollment date in writing to the enrollee prior to the effective date of disenrollment.	Managed Long Term Care Partial Capitation Contract Article V D.1.e	438.210

Focused Surveys

Table 168: Kalos Health's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Kalos Health failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 169: Kalos Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Kalos Health's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for Kalos Health for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2021-2022 review, Kalos Health was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Kalos Health for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	During the 2021-2022 review, Kalos Health was not in full compliance with five standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Kalos Health was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Kalos Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Kalos Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Kalos Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Kalos Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2021-2022 compliance findings. Kalos Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 170: MetroPlus's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, in order to allow for a more thorough assessment of its interventions and implementation approach, MetroPlus should continue its work related to this project for another year. This will allow for an additional point of measurement for the performance indicators.	MetroPlus continues to monitor and review medical documentation associated with emergency department visits and hospitalizations to reduce the rates of both. MetroPlus utilizes a log to track data. Care managers make transition of care follow-up calls to the identified members and encourage provider-focused interventions. This project continuation allows for continuous quality improvement; data is shared with staff monthly for identified trends.	Partially addressed.
Validation of Performance Measures		
MetroPlus should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. MetroPlus should also consider how to maximize realized positive	MetroPlus Uniform Assessment System for New York assessors continue to monitor Uniform Assessment System for New York assessment trends by a Microsoft Excel log. As trends are identified, MetroPlus's Assessment Team notifies the Care Management Team on Uniform Assessment System for New York assessment trends so that care management can follow-up with members and make revisions to the member's person-centered service plan as deemed appropriate. Reeducation of staff and interventions are completed as needed. Their goal is to make members more informed regarding medication, disease, treatment, and	Partially addressed.

2021 External Quality Review Recommendation	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
outcomes of the assessment moratorium.	appropriate follow-up for overall management of the member.	
Review of Compliance with Medicaid Standards		
MetroPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	MetroPlus maintains a Compliance Program to ensure adherence to all applicable requirements. This includes an effective system for routine monitoring, auditing, and identifying compliance risks. Through a risk assessment, MetroPlus' Compliance Committee develops an annual compliance workplan which is executed by the Compliance Team. Identified risks such as utilization, grievance, appeals, and claims are included and monitored regularly. Results are reported to MetroPlus's governing body.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
MetroPlus should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	The Customer Experience Survey continues to improve members' access to care. MetroPlus identified a vendor to support continuous monitoring of the net promoter score and customer satisfaction score. MetroPlus added a new vendor, ExpressCare, to increase members' access to providers. MetroPlus implemented trainings to improve customer experience. MetroPlus created "member engagements" to educate members on virtual visits and urgent care. MetroPlus facilitated the Member Advisory Board to gather key member insights on their experience and knowledge of benefits.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 171: MetroPlus's Performance Improvement Project Summary, 2022

MetroPlus's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ MetroPlus aims to increase the rate for social determinants of health screening among new members. ▪ MetroPlus aims to increase the rate for social determinants of health screening among continuously enrolled members. ▪ MetroPlus aims to increase subsequent follow-up to address social determinants of health needs among members with a positive screen using clinical and non-clinical interventions. Member-Focused 2022 Intervention ▪ Monitored members with a positive social determinants of health assessment to ensure implementation of at least one intervention. Managed Care Plan-Focused 2022 Interventions ▪ Enabled a system generated report to support quarterly monitoring of members with social determinants of health needs. ▪ Trained care managers on the use of the social determinants of health screening tool and appropriate selection of interventions.

Table 172: MetroPlus's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	44.75%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	63.03%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	5.28%	50.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	32.93%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	96.71%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 173: MetroPlus's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** MetroPlus failed to consistently treat concurrent reviews as expedited and respond to member appeals within the required timeframe.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 174: MetroPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Three performance measure rates calculated by the Department of Health for MetroPlus for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	MetroPlus was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, MetroPlus should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	MetroPlus should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	faced limited access to care, or experienced unfavorable health outcomes. To address this, MetroPlus should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	MetroPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 175: Montefiore's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Montefiore's Response	IPRO's Assessment of Montefiore's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Montefiore should continue to monitor member utilization and promote use of appropriate settings of care.	Montefiore continues to prioritize and track member emergency department and hospitalization utilization. Montefiore received daily emergency department/hospital reports generated from their electronic medical record, and admission, discharge, and transfer event notifications from their partner, CarePort, that are shared with care management staff for follow-up. Care managers complete transition of care assessments for emergency department and hospital discharges. Mailings identifying alternate sites for urgent care are mailed to members annually.	Partially addressed.
Validation of Performance Measures		
Montefiore should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Montefiore should also consider how to maximize realized positive outcomes of the assessment moratorium.	During the moratorium, Montefiore care managers continued to complete comprehensive reassessments in the electronic medical record every six months and re-evaluated members' care needs. The assessment included assessing clinical, functional, behavioral, and service-level status. If changes were identified, non-routine assessments were completed. Person-centered service plans were reviewed, updated, and implemented to ensure that services met all of the member's identified care needs.	Partially addressed.
Review of Compliance with Medicaid Standards		
Montefiore should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Montefiore has a clinical care management structure that supports oversight and monitoring of staff and processes to ensure compliance with federal and state Medicaid standards. Montefiore has a robust suite of reports directly from their electronic medical record to monitor continued member eligibility, monthly member outreach, person-centered service plan completion, and referral authorizations. Montefiore's clinical	Partially addressed.

2021 External Quality Review Recommendation	Montefiore's Response	IPRO's Assessment of Montefiore's Response
	management staff audit records and provide daily guidance to staff in the form of utilization management and complex case conferences.	
Administration of Quality-of-Care Surveys – Member Experience		
Montefiore should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Montefiore did not have any areas where performance was significantly worse than the Medicaid managed long-term care average performance; however, Montefiore continued to focus on multiple areas captured on the survey. In an attempt to improve dental scores, Montefiore sent out a targeted education mailing focusing on dental health and access. Montefiore worked with their dental provider to implement dental home visits and dental telehealth visits to address access and improve utilization.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 176: Montefiore's Performance Improvement Project Summary, 2022

Montefiore's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Montefiore aims to increase screening and follow-up rates for social determinants of health needs to all continuously enrolled adult members. Managed Care Plan-Focused 2022 Interventions ▪ Trained all care management staff on social determinants of health. ▪ Conducted community resource referral platform training for all care management staff. ▪ Updated program description and workflows to incorporate social determinants of health screening and interventions more frequently.

Table 177: Montefiore's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	90.43%	95.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	92.72%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	15.23%	16.67%
Percentage of members with a positive social determinants of health assessment	No Data To Report	2.53%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	86.67%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 178: Montefiore's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 179: Montefiore's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Montefiore's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for Montefiore for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Montefiore was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Montefiore for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Montefiore should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Montefiore should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Montefiore should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Montefiore should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 180: Nascentia's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Nascentia's Response	IPRO's Assessment of Nascentia's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Nascentia should continue to monitor member utilization and promote use of appropriate settings of care.	Acute care use is monitored and reported to Nascentia's Quality Committee every quarter. Nascentia provides ongoing education to staff and communicate with members through their newsletter about ways to prevent unnecessary hospital stays. Nascentia has enhanced disease management initiatives, widened access to health information exchanges for optimized care coordination, and are ensuring timely follow-ups. Monthly check-ins allow Nascentia to identify changes in health status and ensure health related social issues are addressed.	Partially addressed.
Validation of Performance Measures		
Nascentia should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Nascentia should also consider how to maximize realized positive outcomes of the assessment moratorium.	Each reassessment is critically reviewed to ensure that any gaps or issues with members are identified and resolved as soon as possible. Nascentia care managers have become more skilled in telephonic assessment and now, coupled with in-person evaluations, provides an effective approach to member assessments and enhances Nascentia's overall member care strategy.	Partially addressed.
Review of Compliance with Medicaid Standards		
Nascentia should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Nascentia should conduct internal reviews as it prepares for the compliance review	Compliance indicators as outlined in the compliance plan are monitored on a monthly basis and overseen by Nascentia's Compliance Committee. Routine compliance education is provided to staff throughout the year and reinforced at all team meetings. Comprehensive audit findings and any recommended interventions are shared with Nascentia leadership and their Quality Committee for Action.	Partially addressed.

2021 External Quality Review Recommendation	Nascentia's Response	IPRO's Assessment of Nascentia's Response
conducted by the Department of Health.		
Administration of Quality-of-Care Surveys – Member Experience		
Nascentia should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Nascentia prioritizes enhancing member satisfaction and is emphasizing initiatives regarding advance directives. Staff regularly receive training to ensure health care proxies are not only revisited but also valid, with appropriate, informed proxies for members and documentation on file. Records are consistently audited, and findings are communicated to Nascentia's Leadership and Quality Committee Teams for subsequent actions.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 181: Nascentia's Performance Improvement Project Summary, 2022

Nascentia's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Nascentia aims to increase screening and follow-up rates for social determinants of health needs among all managed long-term care members by using clinical and non-clinical interventions. Member-Focused 2022 Intervention ▪ Documented social determinants of health findings that required intervention(s) within the member's care plan along with a resolution. Managed Care Plan-Focused 2022 Intervention ▪ Provided training and education to care managers regarding the prevalence, impact, and mitigation of social determinants of health among the managed long-term care population.

Table 182: Nascentia's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	41.64%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	26.05%	50.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	58.48%	75.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	72.02%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	32.91%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Table 183: Nascentia's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	C
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	C
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 184: Nascentia's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Nascentia failed to provide executed contracts between Nascentia and the social day care provider that included required provisions.	Managed Long Term Care Partial Capitation Contract Article VII Section C.2 (a)	438.206
Current person centered service plans on record lacked member specific detail. In addition, person centered service plans did not consistently indicate the scope, duration, and frequency of services.	Managed Long Term Care Partial Capitation Contract Article V J.1 Article V J.9.c.i.v.	438.208
Eighteen records that indicated the enrollee is receiving consumer directed personal assistance services did not contain physician's orders that covered the full review period or the physician's orders were not completed as required.	New York State Public Health Law Title 18	438.208
For nine prior authorization or concurrent reviews following a service request, no evidence was provided that Nascentia either notified the enrollee of the	Managed Long Term Care Partial Capitation Contract Appendix K	438.210

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
decision in writing or that the decision was sent within the required timeframe.		
Eleven decisions pertaining to a reduction did not identify a change in medical condition, mental condition or social circumstance that supports the reduction. In particular, Nascentia failed to properly identify the specific mistake that occurred in the previous assessment or reauthorization and explain why the prior services are not needed as a result of the mistake.	Managed Long Term Care Partial Capitation Contract Policy 16.06	438.210
Six enrollees identified as being involuntarily disenrolled did not include evidence that Nascentia provided the proposed disenrollment date in writing to the enrollee prior to the effective date of disenrollment.	Managed Long Term Care Partial Capitation Contract Article V D.1.e	438.210

Focused Surveys

Table 185: Nascentia's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Nascentia failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 186: Nascentia's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Nascentia's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Nascentia was in compliance with eleven standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	None.			
Performance Measures	Five performance measure rates calculated by the Department of Health for Nascentia for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Nascentia was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Nascentia was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Nascentia should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Nascentia should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Nascentia should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Nascentia should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Nascentia should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 187: Prime Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Prime Health's Response	IPRO's Assessment of Prime Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Prime Health should continue to monitor member utilization and promote use of appropriate settings of care.	Prime Health continues to run monthly reports to monitor members' usage of emergency room and hospitalization settings. Care managers continue to provide member education on disease management, monitoring of symptoms, improving medication adherence, and promoting continuity of care. Between the year of 2021 to 2022, the percentage rate of hospitalizations had dropped more than 10% and emergency room utilization more than 20%.	Addressed.
Validation of Performance Measures		
Prime Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Prime Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	The Uniform Assessment System for New York routine assessment was waived from March 18th, 2020, to July 2021 due to the COVID-19 pandemic. Prime Health conducted its six-month re-evaluation assessments via telehealth, and later, in person. Monthly meetings were conducted to identify barriers with proper follow-up. Statistical data shows an improvement rate in documentation on member care plans. The alerts obtained from HIXNY and Health Connection in real-time to connect with Prime Health members definitely assisted Prime Health in making this project successful.	Partially addressed.
Review of Compliance with Medicaid Standards		
Prime Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Prime Health's Quality Assurance Department continues to work with their Care Management Team to address and improve the quality of care that is delivered to members while keeping in mind the impact of the unnecessary expenses of Medicaid benefits. Findings will continue to be shared with vendors/providers as needed and	Partially addressed.

2021 External Quality Review Recommendation	Prime Health's Response	IPRO's Assessment of Prime Health's Response
	during monthly utilization review meetings with Prime Health's Care Management Team, administration, and medical director.	
Administration of Quality-of-Care Surveys – Member Experience		
Prime Health should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Care managers and visiting nurses were re-educated and library texts were incorporated for care managers to provide information about Prime Health every six months and as needed. Findings were shared with clinicians and processes are in place.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 188: Prime Health's Performance Improvement Project Summary, 2022

Prime Health's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aim ▪ Prime Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Prime Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment who received education on health management strategies. ▪ Prime Health aims to increase the percentage of members with a positive social determinants of health assessment who have a documented intervention to address their need(s). Member-Focused 2022 Interventions ▪ Screened members for social determinants of health needs and made resource referrals when appropriate. Managed Care Plan-Focused 2022 Intervention ▪ Educated staff on the prevalence and health impacts of social determinants of health.

Table 189: Prime Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	87.69%	25.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	92.73%	30.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	90.00%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	64.81%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	94.05%	50.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 190: Prime Health's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 191: Prime Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Prime Health's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Prime Health for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Prime Health was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Prime Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Prime Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	faced limited access to care, or experienced unfavorable health outcomes. To address this, Prime Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Prime Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 192: RiverSpring's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	RiverSpring's Response	IPRO's Assessment of RiverSpring's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, RiverSpring should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	RiverSpring nurse care managers coordinate care when RiverSpring is notified by speaking with the facility, a designated representative, and/or the member during the event to anticipate the discharge needs. The nurse care manager assists the member with scheduling follow-up appointments, ensures all supplies and equipment are in place, and provides education on medications and managing their illness to prevent future hospitalizations. A Uniform Assessment System for New York assessment will be completed, if appropriate, and the care plan updated.	Addressed.
Validation of Performance Measures		
RiverSpring should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. RiverSpring should also consider how to maximize realized positive outcomes of the assessment moratorium.	RiverSpring continued the comprehensive assessment with a review of the person-centered service plan every 6 months and as needed to assess for needed changes based on the member's needs. This way, RiverSpring was able to provide member-centric, individualized care throughout the moratorium. RiverSpring nurse care managers also have a collaborative relationship with their members. Telehealth utilization increased by industry as a result of the moratorium; it could be a tool used by the nurse care manager when a face-to-face visit is urgent.	Partially addressed.
Review of Compliance with Medicaid Standards		
RiverSpring should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020 compliance findings. RiverSpring should conduct internal reviews as it prepares for the	RiverSpring routinely conducts internal and external reviews of key performance indicators and shares results with stakeholders to identify any variations from regulations and established workflow so an item is then addressed to ensure high-quality care is delivered to the	Partially addressed.

2021 External Quality Review Recommendation	RiverSpring's Response	IPRO's Assessment of RiverSpring's Response
compliance review conducted by the Department of Health.	membership. Corrective action plans have been implemented to address past deficiencies.	
Administration of Quality-of-Care Surveys – Member Experience		
RiverSpring should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	RiverSpring has a partnership with their members, working together to ensure members have all the services and supports needed to improve their health and quality of life. This shows in the results of the member satisfaction survey where RiverSpring is performing better than most plans. RiverSpring recognizes many of their members are hesitant to discuss or create a document for appointing health decisions and have again launched an education campaign to inform and support members in stating their preferences.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 193: RiverSpring's Performance Improvement Project Summary, 2022

RiverSpring's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessment within the first 30 days of enrollment for all new managed long-term care members. ▪ RiverSpring aims to increase the percentage of completed stand-alone social determinants of health assessments for all continuously enrolled managed long-term care members. ▪ RiverSpring aims to increase the percentage of care manager contacts where a social determinants of health screen is conducted for all newly and continuously enrolled managed long-term care members. ▪ RiverSpring aims to decrease the percentage of positive social determinants of health assessments for all newly and continuously enrolled managed long-term care members. ▪ RiverSpring aims to increase the percentage of documented interventions to address needs for all managed long-term care members with a positive social determinants of health assessment. Member-Focused 2022 Interventions ▪ Added a recurring section to the member newsletter on social determinants of health to provide ongoing education and resources to members. ▪ Added social determinants of health education to be discussed on monthly care management calls to members. Managed Care Plan-Focused 2022 Interventions ▪ Trained staff on the social determinants of health screening tool, the prevalence and health impacts of social determinants of health, and community resources, which will be repeated annually for all staff and at orientation for new hires. ▪ Constructed a searchable inventory of local resources and supports organized by location and need. ▪ Integrated the social determinants of health assessment tool into existing systems utilized by care management. ▪ Developed a monitoring system within existing care management systems and workflows to ensure close-loop process for referring members to community services and supports.

Table 194: RiverSpring's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	22.42%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	24.49%	40.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	1.79%	8.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	3.15%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	54.03%	60.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Managed Care Operational Survey

Table 195: RiverSpring's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	C
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	C
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 196: RiverSpring's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
RiverSpring failed to provide evidence of board level accountability for overall oversight of program activities and review of the quality assurance and performance improvement program.	Managed Long Term Care Partial Capitation Contract Article V Section F.1(a)	438.242
Of the 50 records submitted for review, two lacked timely reassessments during the review period.	Managed Long Term Care Partial Capitation Contract Article V J. 7	438.208
Plans of care on record do not consistently indicate the scope of services or include all authorized services. In addition, eight current plans of care contain incomplete information.	Managed Long Term Care Partial Capitation Contract Article V J. 1 Article V J. 9. c. i. v.	438.208
Of the 15 records that indicated the enrollee was consumer directed personal assistance services, 12 did not contain a physician's order template that was approved by the Department of Health for utilization.	New York State Public Health Law Title 18	438.208
Of the 50 records submitted for review, 22 contained care management notes that were not sufficiently detailed to demonstrate appropriate follow up and coordination of care. In addition,	Managed Long Term Care Partial Capitation Contract Article V J. 1	438.208

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
care management notes did not consistently document member service requests and/or appeals.		
For 22 prior authorization and concurrent reviews following a service request, evidence was not provided that RiverSpring either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
For three records that contained an involuntary disenrollment, evidence was not provided that RiverSpring initiated disenrollment within the required timeframe.	Managed Long Term Care Partial Capitation Contract Article V D.4.b	438.210

Focused Surveys

Table 197: RiverSpring's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 198: RiverSpring's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	RiverSpring's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for RiverSpring for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	During the 2020-2021 review, RiverSpring was in compliance with eleven standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	RiverSpring was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Five performance measure rates calculated by the Department of Health for RiverSpring for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2020-2021 review, RiverSpring was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, RiverSpring should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	RiverSpring should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, RiverSpring should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	RiverSpring should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. RiverSpring should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 199: Senior Health Partners' Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Senior Health Partners' Response	IPRO's Assessment of Senior Health Partners' Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Senior Health Partners should continue to monitor member utilization and promote use of appropriate settings of care.	Health information exchange integration has been expanded, along with notification of inpatient/emergency department admissions for discharge planning and coordination of care post-discharge. A clinical application tool was created that displays healthcare services received, labs, HEDIS, medication adherence, and managed long-term care preventative gaps-in-care to facilitate care planning, education, and coordination. A clinical education and training team was created and clinical resources were added (MCG and Relias) to develop clinical acumen of care managers.	Partially addressed.
Validation of Performance Measures		
Senior Health Partners should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Senior Health Partners should also consider how to maximize realized positive outcomes of the assessment moratorium.	A clinical application tool was created, layered over the electronic medical record, exposing lab results, medication adherence, HEDIS, and/or managed long-term care gaps-in-care for education, and coordination of preventative screenings. A comprehensive telephonic assessment has been implemented to continue assessing members for changes in condition or decline, and specialized diabetes and social determinants of health assessments have been developed with care planning pathways to support social determinants of health barriers, or gaps in knowledge/services and clinical decline.	Partially addressed.
Review of Compliance with Medicaid Standards		
Senior Health Partners should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2018-2019 compliance findings. Senior	Senior Health Partners has a robust internal corrective action process to mitigate issues and prevent repeat occurrences. The 2018-2019 internal corrective action plans have been successfully implemented and closed. All relevant business units review prior results to confirm compliance with federal and state Medicaid standards. In addition,	Partially addressed.

2021 External Quality Review Recommendation	Senior Health Partners' Response	IPRO's Assessment of Senior Health Partners' Response
Health Partners should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Senior Health Partners' Compliance and Regulatory Teams work collaboratively to monitor and review ongoing compliance.	
Administration of Quality-of-Care Surveys – Member Experience		
Senior Health Partners should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Senior Health Partners has implemented a multi-pronged strategy to improve member satisfaction, including training care management staff to use motivational interviewing, adding probing questions to the proxy member satisfaction survey to ensure care managers address all member needs during monthly outreach calls, and regularly reviewing member feedback to continue to enhance the overall experience both with care managers and home health aides.	Partially addressed.

Table 200: Senior Health Partners' Performance Improvement Project Summary, 2022

Senior Health Partners' Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Senior Health Partners aims to improve the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Health Partners aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Health Partners aims to improve the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Senior Health Partners aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. Member-Focused 2022 Intervention ▪ Provided educational information on the importance of addressing social determinants of health barriers in achieving positive health outcomes and a compilation of online and community resources on our member website. ▪ Conducted follow-up outreach to members within 30 days of the implementation of an intervention addressing a social determinant of health barrier. Managed Care Plan-Focused 2022 Interventions ▪ Integrated a social determinants of health screening tool within Senior Health Partners' care management software, TruCare, that assesses housing instability, safety, food insecurity, social isolation, and financial hardship. ▪ Enhanced functionality in the care management system to trigger evidence-based interventions when a social determinants of health need is identified. ▪ Developed a care management workflow that ensures the social determinants of health screening of members within 30 days of enrollment, and annually for members enrolled longer than six months. ▪ Facilitated training and developed a job aide to educate case management staff on the new tools for social determinants of health screening/care planning, as well as the social determinants of health workflow.

Table 201: Senior Health Partners' Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	45.77%	50.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	91.79%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	13.54%	25.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	11.40%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	46.49%	75.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 202: Senior Health Partners' Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Senior Health Partners failed to consistently respond to service authorization requests within the required timeframe. **Deficiency 2:** Senior Health Partners failed to consistently respond to internal appeal requests within the required timeframe. **Deficiency 3:** Senior Health Partners failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification, with one packet sent after the member's fair hearing.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 203: Senior Health Partners' Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Health Partners' performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Senior Health Partners for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Senior Health Partners for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	Senior Health Partners was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Health Partners should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Senior Health Partners should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Health Partners should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Senior Health Partners should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 204: Senior Network Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Senior Network Health's Response	IPRO's Assessment of Senior Network Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Senior Network Health should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Senior Network Health has continued previously implemented interventions from the performance improvement project as part of best practices. Additionally, care managers are now contacting enrollees following an inpatient discharge within three business days. The purpose of this contact serves to follow-up on post-acute referrals and to identify/address any unmet needs or gaps-in-care during the transition process.	Partially addressed.
Validation of Performance Measures		
Senior Network Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Senior Network Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	The reassessment moratorium very much limited availability of critical enrollee data that would typically drive staff education and quality improvement measures for Senior Network Health. During the moratorium, Senior Network Health sought to improve the quality and discussion content of monthly care manager contacts with members to best gather critical information. More thorough monthly contacts resulted in earlier identification of enrollee concerns/problems and better opportunity for care manager intervention.	Partially addressed.
Review of Compliance with Medicaid Standards		
Senior Network Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Senior	Since this measurement period, Senior Network Health has implemented corrective measures to ensure and maintain compliance with the required oversight of fiscal intermediaries and social adult day care providers. Additional auditing ensures that the following occur: monthly contacts with members, required forms are in place/that no	Partially addressed.

2021 External Quality Review Recommendation	Senior Network Health's Response	IPRO's Assessment of Senior Network Health's Response
Network Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	conflict exists prior to service authorization, and timely notification of service requests and determinations.	
Administration of Quality-of-Care Surveys – Member Experience		
Senior Network Health should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	Senior Network Health did not meet Managed Long-term Care program averages in two areas: the Rating of the Health Plan measure and the Talked About Appointing for Health Decisions measure. In addition to general customer service training, staff were educated to solicit more enrollee input in routine conversations. For accurate survey response, "appointing for health decisions" is now specific language used in conversation with enrollees versus past practice of referring to documents by title or as advance directives.	Partially addressed.

Table 205: Senior Network Health's Performance Improvement Project Summary, 2022

Senior Network Health's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Senior Network Health aims to increase the percentage of social determinants of health assessments occurring within the first 30 days of enrollment for new members. ▪ Senior Network Health aims to increase the number of annual social determinants of health assessments for continuously enrolled members. ▪ Senior Network Health aims to increase the number of care manager contacts where a social determinants of health assessment is completed. ▪ Senior Network Health aims to improve identification of social determinants of health disparities for members. ▪ Senior Network Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). Member-Focused 2022 Interventions ▪ Educated members about social determinants of health, potential impacts of unaddressed disparities, and goals to link members with helpful resources. ▪ Referred members to services and supports as needed. ▪ Conducted monthly follow-up with members who were not able to immediately access referred services to encourage initiation of these services and contacting Community Benefits staff for assistance with changing needs.

Table 206: Senior Network Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	81.82%	90.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	48.32%	85.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	5.41%	7.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	32.95%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	8.62%	85.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Managed Care Operational Survey

Table 207: Senior Network Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	NC
438.236: Practice Guidelines	C
438.242: Health Information Systems	C
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 208: Senior Network Health's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Senior Network Health failed to provide evidence that monitoring of providers is performed for fiscal intermediaries.	Managed Long Term Care Partial Capitation Contract Article VII § C. 1	438.214 438.230
Senior Network Health failed to provide evidence of an executed contract that includes social day care requirements.	Managed Long Term Care Partial Capitation Contract Article VII § C.2 (a)	438.206
Records that indicated the enrollee was receiving consumer directed personal assistance services did not contain a physician's order template that was approved by the Department of Health for utilization.	New York State Public Health Law Title 18	238.208
For 21 prior authorization and concurrent reviews following a service request, no evidence was provided that Senior Network Health either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210

Focused Surveys

Table 209: Senior Network Health's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 210: Senior Network Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Network Health's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Senior Network Health was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Managed Care.*	X	X	X
	Senior Network Health was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Senior Network Health for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Senior Network Health was not in full compliance with five standards of *42 Code of Federal Regulations Part 438 Managed Care.*			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Network Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Senior Network Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Senior Network Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Senior Network Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Senior Network Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 211: Senior Whole Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Senior Whole Health's Response	IPRO's Assessment of Senior Whole Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Senior Whole Health should continue to monitor member utilization and promote use of appropriate settings of care. To ensure future performance improvement project methodologies are effectively designed and managed, Managed Long-Term Care Plan staff should complete performance improvement project refresher trainings, consult the Centers for Medicare & Medicaid Services protocol to ensure the performance improvement project meets all validation requirements, and fully address issues identified by the external quality review organization during the proposal phase, interim reporting phase, and final reporting phase.	Senior Whole Health continues to monitor member emergency department and hospitalization utilization through its Member Health Intelligence Portal. Additionally, Senior Whole Health's Transition of Care Team educates members and monitors their progress for up to 30 days. Senior Whole Health will implement training on the 'plan-do-study-act' model for approaching the development of performance improvement projects, utilizing National Association for Healthcare Quality resource materials as a foundation.	Partially addressed.
Validation of Performance Measures		
Senior Whole Health should evaluate the impact of the	Senior Whole Health assessment nurses resumed community health assessments	Addressed.

2021 External Quality Review Recommendation	Senior Whole Health's Response	IPRO's Assessment of Senior Whole Health's Response
community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Senior Whole Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	annually as of May 2021. In order to maximize positive outcomes, Senior Whole Health implemented daily monitoring of member activity via the Member Health Intelligence Portal, alerting the care manager to changes in condition, such as falls, pain, emergency room visits, etcetera. Senior Whole Health's results are reviewed and shared among the various teams; interventions are implemented regarding plans of care and quality measures.	
Review of Compliance with Medicaid Standards		
Senior Whole Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. Senior Whole Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Senior Whole Health continues with the initiatives put into place to address previous audit findings. Senior Whole Health conducts various internal reviews throughout the year to ensure compliance. Self-monitoring/auditing by department occurs at different frequencies throughout the year. Senior Whole Health's Compliance Department conducts an annual risk assessment, which in turn develops the internal audit work plan; quarterly audits are conducted and corrective action plans are issued for non-compliance.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
Senior Whole Health should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Senior Whole Health implemented a new dental vendor in 2021 and conducts monthly vendor quality meetings to monitor key performance indicators such as dental utilization trends, as well as member grievance and appeals related to access. Routine care coordination meetings are held with members to collaborate on disease management and care plan changes. Additionally, member follow-up occurs to ensure care teams are in-sync with member needs. Weekly vendor oversight meetings address early indicators of timeliness concerns.	Partially addressed.

Table 212: Senior Whole Health's Performance Improvement Project Summary, 2022

Senior Whole Health's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ Senior Whole Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ Senior Whole Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ Senior Whole Health aims to decrease the percentage of members with a positive social determinants of health assessment. ▪ Senior Whole Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). Managed Care Plan-Focused 2022 Interventions ▪ Developed reporting mechanism to identify members with social determinants of health needs based on a completed National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience tool. ▪ Implemented a comprehensive member referral process to support coordination of member linkages to services and supports. ▪ Trained all care management and quality staff on social determinants of health and standardized assessment tool and workflow process.

Table 213: Senior Whole Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	5.48%	75.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	21.13%	75.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	18.39%	48.80%
Percentage of members with a positive social determinants of health assessment	No Data To Report	2.20%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	20.38%	24.50%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Managed Care Operational Survey

Table 214: Senior Whole Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	C
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	NC
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	NC
438.230: Subcontractual Relationships and Delegation	NC
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 215: Senior Whole Health's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Of the seven records pertaining to non-dual enrollees, two contain documentation indicating that the non-dual enrollees were not consistently assessed as eligible for nursing home level of care and therefore do not meet the criteria for participation in a Managed Long Term Care partial capitation plan.	Managed Long Term Care Partial Capitation Contract Article V Section D.4.f	438.210
Of the 50 records submitted for review, two contain an incomplete enrollment agreement that do not demonstrate that the enrollee received all materials required on enrollment; one contains pre-filled content not completed by the enrollee; one does not include an accurate proposed enrollment date; and three do not contain an enrollment agreement in their enrollee record.	Managed Long Term Care Partial Capitation Contract Article V Section C.1 Article V Section H.5	438.242
Of the 50 of records submitted for a review, five lacked timely reassessments during the review period.	Managed Long Term Care Partial Capitation Contract Article V Section J.7	438.208

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Current person-centered service plans on record lack member specific detail and do not consistently indicate the scope, duration, and frequency of services.	Managed Long Term Care Partial Capitation Contract Article V Section J.1 Article V Section J.9.c(i)(v)	438.208
Of the 13 records that indicate the enrollee is receiving consumer directed personal assistance services, six do not contain a complete and/or updated physician's order during the review period.	New York State Public Health Law Title 18	438.208
Of the 50 records submitted for review, 30 contain care management notes that are not sufficiently detailed to demonstrate appropriate follow up and coordination of care; or contain inaccurate or inconsistent information.	Managed Long Term Care Partial Capitation Contract Article V Section J.1 Article V Section J.9.d(vii)	438.208
For five standard grievance or grievance appeals, no evidence was provided that Senior Whole Health either notified the enrollee of the resolution in writing or that the acknowledgement and/or resolution was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228
For 12 prior authorization and concurrent reviews following a service request, no evidence was provided that Senior Whole Health either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.210
Senior Whole Health failed to produce evidence of contracted provider credentialing requirements for background checks and checks against the Medicaid excluded provider lists.	Managed Long Term Care Partial Capitation Contract Article VII Section C.1 Article VIII Section P iii. (A), (C), (D)	438.214
For 10 appeals of decisions resulting from a concurrent review, no evidence was provided that Senior Whole Health notified the enrollee of the decision in writing or that the appeal was treated as an expedited review and the determination was sent within the required timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228
For three appeals of decisions resulting from a termination, suspension, or reduction, no evidence was provided that Senior Whole Health notified the enrollee of the decision in writing or that the decision was sent within the required standard timeframe.	Managed Long Term Care Partial Capitation Contract Appendix K	438.228

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Five adverse determinations pertaining to a reduction did not identify a specific change in medical condition, mental condition, or social circumstance that supports the reduction.	Managed Long Term Care Partial Capitation Contract Policy 16.06	438.210
Senior Whole Health failed to provide evidence that monitoring of providers is performed for fiscal intermediaries.	Managed Long Term Care Partial Capitation Contract Article V11 Section A.1 Article VII Section C. 1	438.214 438.230
Documentation provided by Senior Whole Health identified failure to routinely comply with the Managed Long Term Care partial capitation enrollment denial policy.	Managed Long Term Care Partial Capitation Contract Article V Section B.3.b Article V Section C.1	438.242

Focused Surveys

Table 216: Senior Whole Health's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	**Deficiency 1:** Senior Whole Health failed to consistently respond to service authorization requests within the required timeframe. **Deficiency 2:** Senior Whole Health failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 217: Senior Whole Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Whole Health's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	All performance measure rates calculated by the Department of Health for Senior Whole Health for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2019-2020 review, Senior Whole Health was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019-2020 review, Senior Whole Health was not in full compliance with six standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Senior Whole Health was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Senior Whole Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Senior Whole Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.	X	X	X
Compliance with Federal Managed Care Standards	Senior Whole Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. Senior Whole Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 218: VillageCare's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	VillageCare's Response	IPRO's Assessment of VillageCare's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, VillageCare should continue to monitor member utilization and promote use of appropriate settings of care.	VillageCare continues to monitor emergency department and hospitalization utilization data. VillageCare also developed and distributed member educational materials regarding appropriate levels/settings of care. VillageCare also utilizes care management support for members that are high utilizers and vulnerable.	Partially addressed.
Validation of Performance Measures		
VillageCare should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. VillageCare should also consider how to maximize realized positive outcomes of the assessment moratorium.	During the moratorium, VillageCare continued to assess members every six months telephonically to identify changes in condition. Throughout the moratorium, VillageCare worked closely with community partners to prevent negative outcomes. When the moratorium was lifted, VillageCare worked to complete the backlog of reassessments to identify and address any needs.	Addressed.
Review of Compliance with Medicaid Standards		
VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	VillageCare's Quality Management Department has developed a Quality Management Program and Workplan, which outlines the required standards and metrics for the managed long-term care program. In addition, the Quality Management Program and Workplan identify the stakeholders responsible for ensuring compliance with the standards. The metrics are reported to the Quality Management Improvement Committee	Partially addressed.

2021 External Quality Review Recommendation	VillageCare's Response	IPRO's Assessment of VillageCare's Response
	quarterly. When goals are not met, a corrective action plan is required, and the Quality Management Department follows the corrective action plan through to resolution.	
Administration of Quality-of-Care Surveys – Member Experience		
VillageCare should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	In measurement year 2021, VillageCare scored significantly lower than the program average in the Document Appointing for Health Decisions measure. Since this survey, VillageCare has implemented improvement activities that include developing and distributing member educational materials and discussing advanced directives during monthly calls and member health events. VillageCare encourages members to formulate an advance directive and to provide a copy of their document to VillageCare.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 219: VillageCare's Performance Improvement Project Summary, 2022

VillageCare's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ VillageCare aims to increase stand-alone completed social determinants of health assessments for all members both newly enrolled and continuously enrolled. ▪ VillageCare aims to increase the percentage of care manager contacts where a social determinants of health assessments is conducted and decrease the number of positive social determinants of health assessments. ▪ VillageCare aims to increase the number of members with positive social determinants of health assessments who have documented intervention(s). Managed Care Plan-Focused 2022 Interventions ▪ Conducted follow-up outreach to members with a positive social determinant of health within 90 days of a referral. ▪ Developed educational tools for care managers related to social determinants of health. ▪ Trained care managers on the social determinants of health assessments and community-based organization information.

Table 220: VillageCare's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	89.04%	≥90%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	21.85%	≥90%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	13.00%	≥50%
Percentage of members with a positive social determinants of health assessment	No Data To Report	40.98%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	26.81%	≥90%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Managed Care Operational Survey

Managed Care Operational Survey compliance results are not available for the period under review.

Focused Surveys

Table 221: VillageCare's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results	
Appeals and Fair Hearing Survey	Non-Compliance	Deficiency 1: VillageCare failed to consistently respond to service authorization requests within the required timeframe. Deficiency 2: VillageCare failed to consistently send out evidence packets within 10 business days from the date of the hearing request notification.

Non-Compliance means that at least one deficiency was issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 222: VillageCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VillageCare's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	All performance measure rates calculated by the Department of Health for VillageCare for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	VillageCare was not fully compliant with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VillageCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	VillageCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 223: VNS Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	VNS Health's Response	IPRO's Assessment of VNS Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, VNS Health should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	VNS Health continues efforts in strengthening processes established during the Transition of Care performance improvement project. VNS Health enhanced workflows for better adoption of ADT admission alerts and member outreach following emergency department visits, to support transitional care coordination and reduce admissions. Starting in the fourth quarter of 2023, VNS Health will begin utilizing the new provider portal to support communication with providers. Ongoing key performance indicator monitoring will be conducted during quality committees with stakeholders.	Partially addressed.
Validation of Performance Measures		
VNS Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. VNS Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	Since March 2020, VNS Health began to assess members through virtual means, both annually and when a significant change in condition is identified. This allows VNS Health to continue monitoring members' needs, adjust plans of care, and implement appropriate interventions. VNS Health's goal is to ensure members continue to receive the appropriate care needed and to maintain their wellbeing in the community. VNS Health continues to track of assessment due dates and performing significant change in condition assessments.	Addressed.
Review of Compliance with Medicaid Standards		
VNS Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. VNS Health should conduct	Starting in 2021, VNS Health implemented strategies for continued oversight and ongoing monitoring for alignment with Department of Health requirements. Dashboards are utilized weekly and/or monthly for tracking and validation of metrics. Regular audits occur to review consumer-directed personal assistance service	Partially addressed.

2021 External Quality Review Recommendation	VNS Health's Response	IPRO's Assessment of VNS Health's Response
internal reviews as it prepares for the compliance review conducted by the Department of Health.	orders, claims, service utilization, care coordination, and member satisfaction, to ensure accuracy and maintain timeframes determined by the Department of Health.	
Administration of Quality-of-Care Surveys – Member Experience		
VNS Health should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	VNS Health incorporated satisfaction measures into their contracts with providers to help increase collaboration and partnership with personal care agencies to improve member experience. VNS Health will also administer an off-cycle satisfaction survey on an annual basis to understand the root cause of member satisfaction results. Survey results will be shared with relevant stakeholders to design and implement improvement plans which will be monitored on a regular basis.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 224: VNS Health's Performance Improvement Project Summary, 2022

VNS Health's Partial Capitation Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Partial Capitation
Aims ▪ VNS Health aims to increase the percentage of new enrollees with a completed stand-alone social determinants of health assessment within the first 30 days of enrollment. ▪ VNS Health aims to increase the percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment. ▪ VNS Health aims to increase the percentage of care manager contacts where a social determinants of health screening is conducted. ▪ VNS Health aims to increase the percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s). Member-Focused 2022 Interventions ▪ Referred members with diabetes and a positive social determinants of health assessments for home delivered meals. ▪ Referred members with diabetes and a positive social determinants of health assessment to social adult day care. ▪ Published an article on social determinants of health in the member newsletter. Provider-Focused 2022 Interventions ▪ Conducted an online course educating provider attendees on the Over-the-Counter and Grocery Program benefits. Managed Care Plan-Focused 2022 Interventions ▪ Educated the care management team on Healthify, which provides resources available to aid care managers in linking members to community resources and services not covered by VNS Health. ▪ Educated the care management team on the appropriate use of the enhanced social determinants of health assessment and follow-up workflow procedures.

Table 225: VNS Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	39.12%	15.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	79.85%	15.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	12.76%	Not Required
Percentage of members with a positive social determinants of health assessment	No Data To Report	6.39%	Target Not Established
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	45.62%	40.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Managed Care Operational Survey

Table 226: VNS Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
438.56: Disenrollment: Requirements and Limitations	C
438.100: Enrollee Rights	C
438.114: Emergency and Poststabilization Services	C
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	C
438.208: Coordination and Continuity of Care	NC
438.210: Coverage and Authorization of Services	C
438.214: Provider Selection	NC
438.224: Confidentiality	C
438.228: Grievance and Appeal System	C
438.230: Subcontractual Relationships and Delegation	NC
438.236: Practice Guidelines	C
438.242: Health Information Systems	NC
438.330: Quality Assessment and Performance Improvement Program	C

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

Table 227: VNS Health's Compliance Review Summary of Results, 2020-2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Of the seven records pertaining to non-dual enrollees, two contain documentation indicating that the non-dual enrollees were not consistently assessed as eligible for nursing home level of care and therefore do not meet the criteria for participation in a Managed Long Term Care Partial Capitation plan.	Managed Long Term Care Partial Capitation Contract Article VII Section C. 1	438.214 348.230
Of the 50 records submitted for review, two contain an incomplete enrollment agreement that do not demonstrate that the enrollee received all materials required on enrollment; one contains pre-filled content not completed by the enrollee; one does not include an accurate proposed enrollment date; and three do not contain an enrollment agreement in their enrollee record.	Managed Long Term Care Partial Capitation Contract Article VII Section C.2 (a)	438.206
Of the 50 records submitted for a review, five lacked timely reassessments during the review period.	Managed Long Term Care Partial Capitation Contract Article V C. 1 Article V H. 5	438.242

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Current person centered service plans on record lack member specific detail and do not consistently indicate the scope, duration, and frequency of services.	Managed Long Term Care Partial Capitation Contract Article V J. 1 Article V J. 9. c. v	438.208
Of the 13 records that indicate the enrollee is receiving consumer directed personal assistance services, six do not contain a complete and/or updated physician's order during the review period.	New York State Public Health Law Title 18	438.208

Focused Surveys

Table 228: VNS Health's Partial Capitation Focused Survey Results, 2021-2022

Focused Survey Topic	2021-2022 Results
Appeals and Fair Hearing Survey	In Compliance

In Compliance means that no deficiencies were issued to the Managed Long-Term Care plan.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 229: VNS Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	VNS Health's performance improvement project for the Partial Capitation population passed validation for measurement year 2022.			
Performance Measures	Four performance measure rates calculated by the Department of Health for VNS Health for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	During the 2020-2021 review, VNS Health was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	VNS Health was in compliance with the requirements reviewed during the 2021-2022 focused survey.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, VNS Health was not in full compliance with five standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, VNS Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	VNS Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, VNS Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	VNS Health should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. VNS Health should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Program of All-Inclusive Care for the Elderly Managed Care Plan-Level Reporting

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 230: ArchCare's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	ArchCare's Response	IPRO's Assessment of ArchCare's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, ArchCare should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Transitions in care best practices continue to be tracked and updated. Utilization of the emergency department and hospital are monitored and reported monthly. Causes for re-admission are examined and risk reduction strategies are implemented since the end of the 2021 measurement period of the performance improvement project. These include: ▪ Adopting a patient-centered approach, ▪ Ensuring timely appointments post-discharge, and ▪ Improved fidelity of real-time data for timely response by the clinical team.	Partially addressed.
Validation of Performance Measures		
ArchCare should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. ArchCare should also consider how to maximize realized positive outcomes of the assessment moratorium.	ArchCare is in the process of assessing the prevalence noted in the community health reassessment in the context of the health of Program of All-Inclusive Care for the Elderly participants. An initiative will be undertaken to address the negative health outcomes associated with the findings. This analysis will be tracked and reported to the appropriate governing bodies, including (but not limited to) the Centers for Medicare and Medicaid Services, the Department of Health, and ArchCare's Quality Board.	Partially addressed.
Review of Compliance with Medicaid Standards		
ArchCare should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	ArchCare has hired a special consultant to assist in conducting internal audits to ensure areas of risk are identified, impact analysis is conducted, and findings are mitigated in a timely manner. This includes (but is not limited to) the following areas: service determination requests, appeals, grievances, provision, and quality of care in multiple domains.	Partially addressed.

2021 External Quality Review Recommendation	ArchCare's Response	IPRO's Assessment of ArchCare's Response
Administration of Quality-of-Care Surveys – Member Experience		
ArchCare should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	ArchCare has implemented an initiative to improve participant experience/satisfaction. The project incorporates questions that allow participants to share what matters most and their preferences in care. Care is then aligned with these parameters and is documented in the care plan.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 231: ArchCare's Performance Improvement Project Summary, 2022

ArchCare's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risrisk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aim ▪ ArchCare aims to increase screenings for social determinants of health and follow-up for all members. Managed Care Plan-Focused 2022 Interventions ▪ Trained social workers on workflows related to assessments and data collection for all five social determinants of health domains.

Table 232: ArchCare's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	76.00%	76.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	64.80%	70.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	60.77%	75.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	53.47%	Target Not Established
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	86.67%	90.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 233: ArchCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ArchCare's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	Four performance measure rates calculated by the Department of Health for ArchCare for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ArchCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	ArchCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ArchCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	ArchCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 234: Catholic Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Catholic Health's Response	IPRO's Assessment of Catholic Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Catholic Health should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Catholic Health continues to utilize the discharge risk assessment post-hospitalization to home. This is completed by Catholic Health's Interdisciplinary Team. It reviews the reason for hospitalization and any new diagnoses. It covers any need for new durable medical equipment or treatments. It also reviews fall risk and need for therapy. An assessment is also completed for members transitioning from rehabilitation to home.	Partially addressed.
Validation of Performance Measures		
Catholic Health should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Catholic Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	Catholic Health continues to complete a community health reassessment as needed with a significant change in condition. Participants are assessed and care is ordered accordingly, whether it is a treatment or a need for higher level of care.	Partially addressed.
Review of Compliance with Medicaid Standards		
Catholic Health should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	Catholic Health ensures continued compliance with federal and state Medicaid standards. All staff are educated regarding quality and compliance annually and as needed.	Partially addressed.

2021 External Quality Review Recommendation	Catholic Health's Response	IPRO's Assessment of Catholic Health's Response
Administration of Quality-of-Care Surveys – Member Experience		
Catholic Health should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Catholic Health was one percentage point under the Medicaid managed long-term care average rate for the measure Talked About Appointing for Health Decisions. Catholic Health's rate was at 100% for the measure Document Appointing for Health Decisions. Catholic Health's Social Work Team starts the conversation on initial enrollment.	Remains an opportunity to be addressed.

Performance Improvement Project Summary and Results, 2022

Table 235: Catholic Health's Performance Improvement Project Summary, 2022

Catholic Health's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aim ▪ Catholic Health aims to increase the use of the Accountable Health Communities Health-Related Social Needs screening tool among new and continuing members. Managed Care Plan-Focused 2022 Interventions ▪ Educated care managers and social workers on the use and implementation of the Accountable Health Communities Health-Related Social Needs screening tool. ▪ Social workers worked with community partners to ensure follow-up for members social determinants of health need(s) (housing insecurity, inadequate food, financial instability, social isolation, and unsafe living situations). ▪ Social workers advocated for and worked with community partners to ensure housing security.

Table 236: Catholic Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	100.00%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	0.48%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%[1]	33.00%

[1] Denominator=1.

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 237: Catholic Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Catholic Health's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Catholic Health for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Catholic Health for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Catholic Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Catholic Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Catholic Health should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Catholic Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 238: CenterLight's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	CenterLight's Response	IPRO's Assessment of CenterLight's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, CenterLight should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Our continuous improvement strategy maintains successful performance improvement project interventions, expanding our care team with palliative clinicians for at-home care. Ongoing standard care includes a 30-day post-discharge follow-up to meet care needs and prevent readmissions. Goals: ▪ Hospital admissions: <350 per 1,000 ▪ 30-day readmission rate: <15% ▪ Average length of stay: <5.5 days Monthly data analysis tracks participant outcomes against goals, triggering interdisciplinary interventions for non-achievers.	Partially addressed.
Validation of Performance Measures		
CenterLight should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. CenterLight should also consider how to maximize realized positive outcomes of the assessment moratorium.	While no 2021 external quality review feedback was given in the report, Uniform Assessment System assessment data is analyzed for service, health, and wellness gaps-in-care. Identified gaps-in-care trigger action from CenterLight's Clinical Assessment Team and Interdisciplinary Team, enhancing future assessments. Monthly and quarterly data aggregation shows improvement opportunities, which are shared at CenterLight's regional quality meetings and with their Quality Improvement Committee. Annual evaluation of assessment-derived performance measures informs ongoing processes and identifies areas for improvement.	Partially addressed. (IPRO disagrees with CenterLight's opening statement. Feedback in the form of a recommendation was provided to CenterLight in the *2021 Annual External Quality Review Report*.)
Review of Compliance with Medicaid Standards		
CenterLight should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review	CenterLight will continue to adhere to federal and state Medicaid regulatory standards for the Program of All-Inclusive Care for the Elderly population, maintaining compliance with the Centers for Medicaid and Medicare Services.	Partially addressed.

2021 External Quality Review Recommendation	CenterLight's Response	IPRO's Assessment of CenterLight's Response
conducted by the Centers for Medicare & Medicaid Services.	Note: Medicaid and Children's Health Insurance Program standards are not applicable to our population.	
Administration of Quality-of-Care Surveys – Member Experience		
CenterLight should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	CenterLight's top three areas for improvement: ▪ Urgent dental care: CenterLight will work with dental vendors to ensure adequate network and timeliness is maintained. ▪ Home health aide rating: Monthly grievance data is reviewed by CenterLight and shared with their partners for action; CenterLight's Quality Improvement Committee reviews this data quarterly. ▪ Participant involvement: Enhancing CenterLight's Interdisciplinary Team communications to engage the participant's involvement. Annually, CenterLight surveys participant satisfaction using the Integrated Satisfaction Measurement for PACE or Department of Health surveys to address areas of concern and improve their health plan rating.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 239: CenterLight's Performance Improvement Project Summary, 2022

CenterLight's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aims ▪ CenterLight aims to increase the percentage of new enrollees with a completed social determinants of health assessment in the first 30 days of enrollment. ▪ CenterLight aims to increase the percentage of continuously enrolled participants with a completed social determinants of health assessment. ▪ CenterLight aims to increase the percentage of social worker contacts where a social determinants of health screening is conducted. ▪ CenterLight aims to decrease the percentage of participants with a documented need resulting from a completed social determinants of health assessment. ▪ CenterLight aims to increase the percentage of documented social determinants of health interventions for participants with a need determined by the social determinants of health assessment. Member-Focused 2022 Interventions ▪ Mailed education to participants on the importance of answering the social determinants of health questions openly and honestly to reduce healthcare disparities and improve their quality of life. Managed Care Plan-Focused 2022 Interventions ▪ Developed a stand-alone social determinants of health domain within the social work comprehensive assessment using 20 questions from the Centers for Medicare and Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool. ▪ Created a reporting system that includes quantification of assessments, positive social determinants of health questions, and interventions documented for care planning. ▪ Educated all social work staff and interdisciplinary team disciplines on methods to present the social determinants of health questions to encourage open and honest responses from participants.

Table 240: CenterLight's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	90.79%	90.50%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	99.75%	87.30%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	59.05%	69.20%
Percentage of members with a positive social determinants of health assessment	No Data To Report	27.33%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	98.49%	95.70%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 241: CenterLight's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	CenterLight's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	Five performance measure rates calculated by the Department of Health for CenterLight for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	One performance measure rate calculated by the Department of Health for CenterLight for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, CenterLight should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	CenterLight should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, CenterLight should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	CenterLight should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 242: Complete Senior Care's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Complete Senior Care's Response	IPRO's Assessment of Complete Senior Care's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Complete Senior Care should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Complete Senior Care continues to track and trend inpatient hospitalizations, emergency room visits, and readmissions. Complete Senior Care also requires participants to be evaluated by a Program of All-Inclusive Care for the Elderly provider within seven days of an emergency room visit or inpatient hospitalization. This data is reviewed quarterly as part of Complete Senior Care's quality and utilization review, is part of their quality improvement plan, and is available for participant review as communicated in Complete Senior Care's Participant Advisory Council meetings.	Partially addressed.
Validation of Performance Measures		
Complete Senior Care should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Complete Senior Care should also consider how to maximize realized positive outcomes of the assessment moratorium.	Complete Senior Care maintained the community health assessment through the COVID-19 pandemic and found additional, creative ways to check-in on vulnerable participants safely. One example is Complete Senior Care's home-delivered meals program, which turned their vacant day center into a meal distribution hub for hundreds of meals weekly. Complete Senior Care registered nurses made routine weekly visits, and interdisciplinary team members made well-check calls. Complete Senior Care did see a decline with their participants; however, these assessments gave Complete Senior Care the information needed to adjust plans of care, as necessary.	Partially addressed.
Review of Compliance with Medicaid Standards		
Complete Senior Care should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the	On an annual basis, Complete Senior Care develops a monitoring, auditing, and training workplan. The workplan is developed based on trends identified during analysis of internal data and changes in federal and state regulations. The workplan includes audits of their high-risk program area's timeframe	Partially addressed.

2021 External Quality Review Recommendation	Complete Senior Care's Response	IPRO's Assessment of Complete Senior Care's Response
compliance review conducted by the Centers for Medicare & Medicaid Services.	for completion, and to whom results are reported to, such as the Complete Senior Care's Compliance Committee, etc.	
Administration of Quality-of-Care Surveys – Member Experience		
Complete Senior Care should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	Complete Senior Care's 2021 Managed Long-Term Care Member Satisfaction Survey results were favorable, showing 88% of responders rating Complete Senior Care as good/excellent and 90% of responders reporting clear communication of services. Participant perception of Quality-of-Care also remained positive from the previous survey. Although Complete Senior Care is pleased with the results of this survey, as well as with their first place ranking in Quality in New York State, Complete Senior Care is committed to working on making improvements in all areas, especially those not meeting benchmark averages.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 243: Complete Senior Care's Performance Improvement Project Summary, 2022

Complete Senior Care's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aims ▪ Complete Senior Care aims to improve the percentage of both new and continuously enrolled participants with a completed stand-alone social determinants of health assessment. ▪ Complete Senior Care aims to maintain the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ Complete Senior Care aims to decrease the percentage of participants with a positive social determinants of health assessment. ▪ Complete Senior Care aims to improve the percentage of members with a positive social determinants of health assessment who have documented interventions to address needs. Managed Care Plan-Focused 2022 Interventions ▪ Conducted training to educate staff regarding the prevalence and health impacts of social determinants of health, particularly among the Program of All-Inclusive Care for the Elderly plan population. ▪ Established protocols to ensure social determinants of health screening occurs at every member assessment. ▪ Developed new workflow to ensure closed-loop process for referring members to community services and supports.

Table 244: Complete Senior Care's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	83.87%	90.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	85.03%	90.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	84.86%	90.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	45.95%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	65.88%	90.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 245: Complete Senior Care's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Complete Senior Care's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	Three of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for Complete Senior Care for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Complete Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	Complete Senior Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Complete Senior Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	Complete Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 246: Eddy SeniorCare's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Eddy SeniorCare's Response	IPRO's Assessment of Eddy SeniorCare's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, Eddy SeniorCare should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	Eddy SeniorCare continues monthly audits for their Transition of Care project: 100% of acute discharge paperwork in the electronic medical record (the goal was 90% within 10 days; currently, Eddy SeniorCare's rate is at 79% within three days). Eddy SeniorCare audits nursing follow-up visit with medication reconciliation within 72 hours of discharge on a random sample of records (the goal is 100%, with a current rate at 79%). Eddy SeniorCare is utilizing HIXNY® Whitelist to improve, and is monitored quarterly by Eddy SeniorCare's Quality Assurance and Performance Improvement Committee. Eddy SeniorCare's readmission rate baseline for 2018 was 25.6%, with a goal of 15.3%; as of June 30th, 2023, the readmission rate was at 15.6% - only 0.3% from their goal.	Addressed.
Validation of Performance Measures		
Eddy SeniorCare should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Eddy SeniorCare should also consider how to maximize realized positive outcomes of the assessment moratorium.	Although the Uniform Assessment System reassessment tool was paused, Eddy SeniorCare as a Program of All-Inclusive Care for the Elderly continued to complete semiannual and annual assessments (plan of care reviews by each discipline of their interdisciplinary team) at 100% of participants; this is ongoing. Eddy SeniorCare is current with Uniform Assessment System reassessments since they resumed. Eddy SeniorCare has an active Quality Assurance and Performance Improvement Program with many initiatives driving outcome improvements. Eddy SeniorCare's readmission baseline was 25.62% in 2018, with a target of 15.3%; as of June 30th, 2023, Eddy SeniorCare's rate was at 15.6% - only 0.3% from their goal.	Partially addressed.

2021 External Quality Review Recommendation	Eddy SeniorCare's Response	IPRO's Assessment of Eddy SeniorCare's Response
Review of Compliance with Medicaid Standards		
Eddy SeniorCare should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	Eddy SeniorCare has an active Compliance and Integrity Program, which meets quarterly to monitor compliance and implement action plans. Eddy SeniorCare completes an annual vulnerability assessment, targets internal monitoring audits, and creates workplans to address areas of risk. Eddy SeniorCare's senior leadership meets monthly to implement new regulations, continually audits compliance, and takes corrective actions.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, Eddy SeniorCare should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Eddy SeniorCare engages an external vendor, Vital Research, to complete a participant satisfaction survey annually. Results are shared with all staff and opportunities for improvement are included in Eddy SeniorCare's annual Quality Assurance and Performance Improvement goals and action plans. The results of the survey are also shared with their Participant Advisory Council for input. Eddy SeniorCare scored 94% for overall participant satisfaction from the September 2022 survey; the next survey is scheduled for September 2023.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 247: Eddy SeniorCare's Performance Improvement Project Summary, 2022

Eddy SeniorCare's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aims ▪ Eddy SeniorCare aims to complete social determinants of health screening for 90% of newly enrolled members, and 80% of continuously enrolled members at the 6-month assessment period. ▪ Eddy Senior Care aims to have documented interventions for 80% of members who screen positive on social determinants of health assessment. Managed Care Plan-Focused 2022 Interventions ▪ Built a tool in the electronic medical record to assess five domains of social determinants of health (financial insecurity, safety, social isolation, food insecurity, and housing insecurity) at the time of admission, after 6 months, and as needs arise. ▪ Trained staff in how to properly document social determinants of health and interventions within the electronic medical record system.

Table 248: Eddy SeniorCare's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	98.59%	80.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	87.84%	80.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	89.63%	30.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	19.40%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	80.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 249: Eddy SeniorCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Eddy SeniorCare's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	Two performance measure rates calculated by the Department of Health for Eddy SeniorCare for measurement year 2022 performed statistically significantly better than the statewide Medicaid Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Eddy SeniorCare for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Eddy SeniorCare should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Eddy SeniorCare should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Eddy SeniorCare should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Eddy SeniorCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 250: ElderONE's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	ElderONE's Response	IPRO's Assessment of ElderONE's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, ElderONE should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	ElderONE updated and revised their internal transitions in care reporting tool to ensure increased tracking accuracy and timeliness of information sharing. Additionally, ElderONE holds daily interdisciplinary calls to discuss and review the status and transition plans for every member in an alternate care setting. ElderONE revised their post-hospitalization touchpoints program and amended their electronic medical record to more easily identify participants at higher risk for readmissions.	Partially addressed.
Validation of Performance Measures		
ElderONE should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. ElderONE should also consider how to maximize realized positive outcomes of the assessment moratorium.	ElderONE has centralized the Uniform Assessment System assessment process with the addition of a small team of registered nurses, specifically dedicated to conducting the Uniform Assessment System assessment. The participants' interdisciplinary teams, along with the Uniform Assessment System assessment nurses, review upcoming (due) Uniform Assessment System assessments, schedule them, and ensure that each is completed in time. This centralization allows clarity in scheduling the assessments as well as tracking for completion. However, this moratorium does not apply to the Program of All-Inclusive Care for the Elderly.	Partially addressed.
Review of Compliance with Medicaid Standards		
ElderONE should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for	ElderONE continues to utilize internal auditing tools to perform monthly medical record audits on a randomized sample of active and disenrolled participants.	Partially addressed.

2021 External Quality Review Recommendation	ElderONE's Response	IPRO's Assessment of ElderONE's Response
Medicare & Medicaid Services.		
Administration of Quality-of-Care Surveys – Member Experience		
ElderONE should work to improve its performance on measures of member satisfaction for which it did not meet the Medicaid Managed Long-Term Care program average.	ElderONE developed an internal meaningful participant rounding tool to better track, understand, and act upon participant dissatisfaction. Additionally, ElderONE reviews all expressions of dissatisfaction, complete interdisciplinary investigations, and enact local and/or systematic change as indicated.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 251: ElderONE's Performance Improvement Project Summary, 2022

ElderONE's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aims ▪ ElderONE aims to maintain a 100% compliance rate for new enrollees who completed a social determinants of health screen within the first 30 days of enrollment. ▪ ElderONE aims to maintain a 100% compliance rate for continuously enrolled members with a completed social determinants of health screen every 6 months. ▪ ElderONE aims to quantify the percentage of care manager contacts where a social determinants of health screen is conducted. ▪ ElderONE aims to decrease the percentage of members with a positive social determinants of health screen. ▪ ElderONE aims to maintain a 100% compliance rate for members with a positive social determinants of health screen with documented interventions to address need(s). Managed Care Plan-Focused 2022 Interventions ▪ Implemented a tracking spreadsheet to quantify how many ElderONE participants have a positive social determinants of health screen. ▪ Created and implemented a tracking spreadsheet to be able to quantify how many ElderONE participants who have a positive social determinants of health screen also have documented interventions on their care plan. ▪ Created and implemented a tracking spreadsheet to quantify how many ElderONE participants who report feeling lonely and have documented intervention for day center attendance in their care plan.

Table 252: ElderONE's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	99.77%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	26.27%	50.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	7.18%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. Not Required indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the External Quality Review Activity 2. Validation of Performance Measures section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 253: ElderONE's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	ElderONE's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for ElderONE for measurement year 2022 performed statistically significantly better than the statewide Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	One of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures	Three performance measure rates calculated by the Department of Health for ElderONE for measurement year 2022 performed statistically significantly worse than the statewide Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, ElderONE should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.	X	X	X
Performance Measures	ElderONE should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, ElderONE should focus on enhancing areas of care where its rates are below the Managed Long-term Care program mean.			
Compliance with Federal Managed Care Standards	ElderONE should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 254: Fallon Health's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Fallon Health's Response	IPRO's Assessment of Fallon Health's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Fallon Health should continue to monitor member utilization and promote use of appropriate settings of care. To ensure future performance improvement project methodologies are effectively designed and managed, Managed Long-Term Care Plan staff should complete performance improvement project refresher trainings, consult the Centers for Medicare & Medicaid Services protocol to ensure the performance improvement project meets all validation requirements, and fully address issues identified by the external quality review organization during the proposal phase, interim reporting phase, and final reporting phase.	Fallon Health has continued to monitor members monthly for primary care provider involvement and linkage with a new primary care provider, when identified as a need in the electronic medical record. Fallon Health has continued to monitor emergency department utilization/hospitalizations and educate members on appropriate use of hospital utilization versus a primary care provider visit need as identified by the regional health information organization or in the electronic medical record, or a phone call to a primary care provider office to discuss use of an emergency department/hospital versus a primary care provider visit when identified as a need in electronic medical record reporting.	Partially addressed.
Validation of Performance Measures		
Fallon Health should evaluate the impact of the community	The community health reassessment moratorium negative impact of health of members with access	Partially addressed.

2021 External Quality Review Recommendation	Fallon Health's Response	IPRO's Assessment of Fallon Health's Response
health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Fallon Health should also consider how to maximize realized positive outcomes of the assessment moratorium.	to timely care and staffing was reviewed and monitored. Staffing was reviewed and increased to improve timely care in addressing needs of members and coordination of care.	
Review of Compliance with Medicaid Standards		
Fallon Health should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Fallon Health has implemented the corrective action plan with monthly and quarterly monitoring as indicated. All items are monitored and managed by Fallon Health's program director to meet requirements.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience		
Fallon Health should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	Quality monitoring of providers and their services, as well as representation to members has been implemented. Fallon Health's provider availability has been reviewed and an update was provided to members; documentation of review is in the electronic medical record to support. Fallon Health's transportation provider continues to show concern from internal auditing of quality due to this provider's reporting and lack of available staffing during times of need. Provider contracts have been reviewed in process to ensure enough providers are available for members.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 255: Fallon Health's Performance Improvement Project Summary, 2022

Fallon Health's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aim ▪ Fallon Health aims to increase utilization of a standalone screening tool for social determinants of health in the electronic health record for enrolled participants. Managed Care Plan-Focused 2022 Interventions ▪ Developed and implemented a standalone tool to capture domains of social determinants of health data and assist with reporting. ▪ Educated staff on social determinants of health, criteria recording, and reporting.

Table 256: Fallon Health's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	28.47%	28.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	34.39%	28.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	100.00%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 257: Fallon Health's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fallon Health's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for Fallon Health for measurement year 2022 performed statistically significantly worse than the statewide Managed Long-Term Care Plan mean.	X		X
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Fallon Health should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Fallon Health should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Fallon Health should focus on enhancing areas of care where its rates are below the Managed Long-term Care program mean.	X		
Compliance with Federal Managed Care Standards	Fallon Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 258: PACE CNY's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	PACE CNY's Response	IPRO's Assessment of PACE CNY's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of transitions of care ended with the 2021 measurement period, PACE CNY should strive to bolster the quality and experience of care members receive during transitions, increase follow-up care post-discharge, and decrease avoidable readmissions.	PACE CNY has a protocol in place where three provider visits are completed in 30 days post-discharge. This policy continues to be utilized by the organization. The expected outcomes or goals of the actions taken is to reduce 30-day readmission rates. This is monitored participant-specific by the PACE CNY Interdisciplinary Team, with bi-weekly emergency room/hospital utilization committee meetings, and with monitoring of quarterly reportable data. The recommendations were not made in the 2020 technical report and reissued in 2021.	Partially addressed.
Validation of Performance Measures		
PACE CNY should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. PACE CNY should also consider how to maximize realized positive outcomes of the assessment moratorium.	PACE CNY's Interdisciplinary Team utilizes the community health reassessment for participant-specific care planning that occurs with the interdisciplinary team's assessments. This is a practice that is ongoing and will continue. The expected outcomes of the actions taken are that care planning will meet the needs of participants based upon their specific needs to allow patient-centric, aging-in-place, with optimized quality of care. The process for monitoring the actions to determine effectiveness is with cognitive assessment and care plan auditing and quarterly data.	Partially addressed.
Review of Compliance with Medicaid Standards		
PACE CNY should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the	PACE CNY's Compliance and Quality Management Department completes review of all pertinent Centers for Medicare and Medicaid Services updates in comparison to current policies, procedures, and practices on an ongoing basis. PACE CNY's expected goal is to remain in compliance with all state and federal regulatory changes that are applicable. The process for	Partially addressed.

2021 External Quality Review Recommendation	PACE CNY's Response	IPRO's Assessment of PACE CNY's Response
Centers for Medicare & Medicaid Services.	monitoring and actions to determine effectiveness are the quarterly quality and compliance review meetings, and there is a monthly group who reviews this.	
Administration of Quality-of-Care Surveys – Member Experience		
PACE CNY should work to improve its performance on measures of member satisfaction for which it did not meet the Managed Long-Term Care program average.	PACE CNY conducts an annual customer satisfaction audit, tracks and addresses grievances, and has made changes to increase staffing where there were shortages. There is ongoing certified home health aide training courses being conducted internally and will continue to be offered monthly ongoing. PACE CNY's goal is to improve certified home health aide staffing with quality individuals. The process for monitoring to determine effectiveness is with quarterly staffing and retention reports. The recommendation was not made in the 2020 technical report.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 259: PACE CNY Performance Improvement Project Summary, 2022

PACE CNY's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aim ▪ PACE CNY aims to demonstrate full compliance with completed social determinants of health assessments. Managed Care Plan-Focused 2022 Interventions ▪ Enhanced PACE CNY's new employee orientation program with a segment focusing on the multifaceted approaches to assess and address social determinants of health under the Program of All-Inclusive Care for the Elderly model of care. ▪ Updated annual employee orientation to re-engage Program of All-Inclusive Care for the Elderly staff in social determinants of health assessment and care planning interventions.

Table 260: PACE CNY's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	100.00%	100.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	100.00%	100.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	100.00%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 261: PACE CNY's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	PACE CNY's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	One performance measure rate calculated by the Department of Health for PACE CNY for measurement year 2022 performed statistically significantly better than the statewide Managed Long-Term Care Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Three performance measure rates calculated by the Department of Health for PACE CNY for measurement year 2022 performed statistically significantly worse than the statewide Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, PACE CNY should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	continued to ensure their contribution towards improvement is sustained. Interventions identified with low impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	PACE CNY should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, PACE CNY should focus on enhancing areas of care where its rates are below the Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	PACE CNY should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 262: Total Senior Care's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Total Senior Care's Response	IPRO's Assessment of Total Senior Care's Response
Validation of Performance Improvement Projects		
Although the state's requirement to continue a performance improvement project on the topic of reducing emergency department and hospitalization utilization ended with the 2021 measurement period, Total Senior Care should continue to monitor member utilization and promote use of appropriate settings of care.	Hospital utilization continues to be monitored and reported on quarterly to assess for trends, high utilizers, and appropriate use of services as part of Total Senior Care's 2023 quality improvement activity plan. Each quarter, Total Senior Care's quality improvement manager compiles the information and reports it to the Centers for Medicare and Medicaid Services, the Department of Health, the quality committee, and the Total Senior Care board. As part of Total Senior Care's plan, the aim is for Total Senior Care to have a rate of less than 50% for emergency room visits for each quarter in 2023. This initiative will continue to be monitored and goals will be adjusted according to need.	Partially addressed.
Validation of Performance Measures		
Total Senior Care should evaluate the impact of the community health reassessment moratorium on the health of its members and on related work processes; and quickly address negative health outcomes. Total Senior Care should also consider how to maximize realized positive outcomes of the assessment moratorium.	During the community health reassessment moratorium, Total Senior Care did not experience any negative health outcomes specifically related to that. Total Senior Care was able to complete all of the assessments in a timely fashion, either in-person, or through telehealth medicine. On some occasions, participants continued to come into the Total Senior Care center. Since the moratorium has been lifted, participants have struggled with no longer being able to utilize telehealth for reassessments but are beginning to adjust.	Partially addressed.
Review of Compliance with Medicaid Standards		
Total Senior Care should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted	Internal reviews are completed routinely by many members of the Total Senior Care team. The auditing of medical records, claims, service requests, environmental conditions, reassessment dates, and care plans are just some areas of continuous auditing and monitoring. Any issues identified as being out of compliance are addressed in a timely	Partially addressed.

2021 External Quality Review Recommendation	Total Senior Care's Response	IPRO's Assessment of Total Senior Care's Response
by the Centers for Medicare & Medicaid Services.	fashion to ensure corrections are made when applicable. Education and training of staff is completed on a frequent basis to ensure up-to-date knowledge is received at every level.	
Administration of Quality-of-Care Surveys – Member Experience		
Despite its small sample size for the member satisfaction survey, Total Senior Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	Total Senior Care is committed to providing the highest level of care possible for our members to ensure their wellbeing and overall satisfaction. Participant satisfaction surveys are sent out yearly to members to assess levels of satisfaction and to identify areas needing improvement. Each survey is then reviewed upon return and results are compiled to share with the Total Senior Care staff and board members.	Partially addressed.

Performance Improvement Project Summary and Results, 2022

Table 263: Total Senior Care's Performance Improvement Project Summary, 2022

Total Senior Care's Program of All-Inclusive Care for the Elderly Performance Improvement Project Summary
Title: Improving Rates of Social Determinants of Health Screening for the Managed Long-Term Care General Membership **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Medicaid Managed Care Population:** Program of All-Inclusive Care for the Elderly
Aims ▪ Total Senior Care aims to increase social determinants of health screening rates of all active members. ▪ Total Senior Care aims to increase follow-up rates for identified social determinants of health needs by using clinical and non-clinical interventions. Managed Care Plan-Focused 2022 Interventions ▪ Established protocols to ensure social determinants of health screening occurs at initial assessments and then quarterly for all active members. ▪ Developed new workflows to ensure close-loop process for referring members to community services and supports. ▪ Trained all staff on the prevalence and health impacts of social determinants of health, particularly among the managed long-term care population.

Table 264: Total Senior Care's Performance Improvement Project Indicator Summary, Measurement Years 2021 and 2022

Measure	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
Percentage of new enrollees with a completed stand-alone social determinants of health assessment	No Data To Report	76.92%	33.00%
Percentage of continuously enrolled members with a completed stand-alone social determinants of health assessment	No Data To Report	89.92%	33.00%
Percentage of care manager contacts where a social determinants of health screen is conducted	No Data To Report	9.03%	33.00%
Percentage of members with a positive social determinants of health assessment	No Data To Report	23.93%	Not Required
Percentage of members with a positive social determinants of health assessment who have documented interventions to address need(s)	No Data To Report	100.00%	100.00%

No Data To Report means that the Managed Long-Term Care plan did not have a standalone social determinants of health assessment in place prior to the implementation of the performance improvement project. **Not Required** indicates that the measure is not being used as a tool to track performance improvement; instead, it is being utilized by the Managed Long-Term Care plan to monitor the progress of the project.

Performance Measure Results, 2022

Performance measure results can be found in the **External Quality Review Activity 2. Validation of Performance Measures** section of this report.

Compliance with Medicaid Standards Results, 2020-2022

Compliance review results are not available for the period under review.

Strengths, Opportunities for Improvement, and Recommendations, 2022

Table 265: Total Senior Care's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Total Senior Care's performance improvement project for the Program of All-Inclusive Care for the Elderly population passed validation for measurement year 2022.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	Four performance measure rates calculated by the Department of Health for Total Senior Care for measurement year 2022 performed statistically significantly worse than the statewide Medicaid Managed Long-Term Care Plan mean.	X		
Compliance with Federal Managed Care Standards	None.			
Recommendations				
Performance Improvement Project	In the ongoing performance improvement project, Total Senior Care should diligently monitor its progress towards established goals. At the same time, an evaluation of the effectiveness of implemented interventions should be conducted. Interventions determined to have high impact should be continued to ensure their contribution towards improvement is sustained. Interventions identified with low	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	impact should be revised or retired and replaced based on the results of a recent barrier analysis.			
Performance Measures	Total Senior Care should utilize the findings from the Department of Health's analysis of health assessment data to shape its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members may have received suboptimal care, faced limited access to care, or experienced unfavorable health outcomes. To address this, Total Senior Care should focus on enhancing areas of care where its rates are below the Medicaid Managed Long-term Care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Total Senior Care should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Centers for Medicare & Medicaid Services.	X	X	X

Appendix A – Centers for Medicare & Medicaid Services' Audit Overview for Program of All-Inclusive Care for the Elderly

Programs of All-Inclusive Care for the Elderly (PACE) Audit Overview

Medicare Parts C and D Oversight and Enforcement Group

Division of Analysis, Policy, and Strategy

Table of Contents

I. Executive Summary – PACE Audit Phase Timeline

Phase I: Audit Engagement and Universe / Data Submission

- ***Engagement Letter* –** CMS notification to PACE organizations of audit selection; identification of audit scope and logistics; and instructions for PACE organizations audit document submissions.
- ***Pre-Field Work Meetings*** – CMS meetings with PACE organizations to provide information about the audit and documentation request processes, and system access requirements.
- ***Pre-Field Work Data Submissions* –** PACE organization submission of initial documentation to CMS; the required documentation is identified in the audit protocol and includes universes and other supplemental documentation.
- ***Audit Sample Selection* –** CMS selection of samples of cases to be tested during field work.

Phase II: Audit Field Work

- ***Entrance Conference* –** Discussion of CMS audit objectives and expectations; PACE organization optional presentation on organization.
- ***Week 1&2 Review* –** CMS testing of sample cases via desk/remote review or live webinar review with the PACE organization; CMS requests for additional information and PACE organization responses; PACE organization submission of requested documentation; CMS documentation analyses; and CMS observation of facility, patient care, transportation vehicles, and review of emergency medical equipment.
- ***Preliminary Draft Audit Report Issuance*** – CMS issuance of a preliminary draft report to PACE organization identifying the preliminary conditions noted during the audit.
- ***Exit Conference* –** CMS review and discussion of preliminary issues of non-compliance with PACE organization.

Phase III: Audit Analysis and Reporting

- ***Condition Classification* –** CMS classification of non-compliance.
- ***Notification of Immediate Corrective Action Required (ICAR) conditions (as applicable)* –** CMS notification to PACE organization of conditions requiring corrective action prior to the issuance of the final report; PACE organization Corrective Action Plan (CAP) submission due within three business days of ICAR notification.
- ***Draft Report Issuance* –** CMS issuance of draft audit report, inclusive of condition classifications, to PACE organization approximately 60-90 calendar days after the last PACE organization data submission is received.
- ***Draft Report Response* –** PACE organization submission of comments to the draft report within 10 business days of draft report receipt.
- ***Final Report Issuance* –** CMS responds to PACE organization comments and updates audit conditions (if applicable); Final report is issued approximately 15-30 calendar days after receipt of the PACE organization's draft report comments.

Phase IV: Audit CAPs and Close Out

- ***Non-ICAR Corrective Action Plan (CAP) Submission* –** PACE organization submission of CAPs for all conditions classified as a Corrective Action Required within 10 business days of receiving the final audit report.
- ***CAP Review and Acceptance* –** CMS CAP reasonableness review and notification to PACE organization of acceptance or need for revision.
- ***CAP Implementation and Release* –** The PACE organization's account manager will provide technical assistance to help ensure the PACE organization is effectively executing corrective action as required. Within 60 days of the final report issuance, CAP implementation is expected and CMS will release the CAPs.
- ***Audit Close Out* –** Once all CAPs have been released, CMS will close the audit.

II. Background

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) is the group within the Centers for Medicare & Medicaid Services (CMS) responsible for creating and administering the audit strategy for the Programs of All-Inclusive Care for the Elderly (PACE) audits[1]. MOEG also oversees, coordinates and conducts the audits of all PACE organizations (POs). These audits measure a PACE organization's compliance with the terms of its contract with CMS, in particular, the regulatory requirements associated with access to services, drugs, and other protections required by Medicare. CMS solicits feedback on the audit process from industry stakeholders through a variety of mediums. CMS uses the feedback to update and improve audit operations as well as to explore new areas that may require oversight.

This document outlines the audit phases for PACE audits. CMS will typically issue engagement letters for scheduled audits from January through September, but this could vary from year to year. Engagement letters for unscheduled audits may be sent at any time throughout the year.

III. Summary of Audit Phases

The PACE audit consists of four phases:

I. Audit Engagement and Universe/Data Submission
II. Audit Field Work
III. Audit Analysis and Reporting
IV. Audit CAPs and Close Out

The following sections describe important milestones in each phase of the audit.

[1] MOEG also oversees, coordinates, and conducts program audits which includes audits of Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), and Medicare-Medicaid Plans (MMPs). Information regarding program audits is posted on the CMS Program Audits Website located at https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/programaudits

Phase I: Audit Engagement and Universe Submission

The Audit Engagement and Universe Submission phase is the six-week period[2] prior to the field work portion of the audit. During this phase, the PACE organization is notified that it has been selected for an audit and is required to submit the requested data, which is outlined in the PACE audit process and data request document. Key milestones for scheduled audits within Phase I include:

Engagement Letter – CMS issues an audit engagement letter via the Health Plan Management System (HPMS). Notification of the engagement letter is sent to the PACE organization's Chief Executive Officer - CMS Administrator Contact designated in HPMS. The engagement letter contains instructions for downloading important audit documents from HPMS as well as key dates and timeframes for documentation submission.

Engagement Letter Follow-Up Call – Within two business days from the date of the engagement letter, the CMS audit team conducts a follow-up call with the PACE organization. The purpose of this call is to provide an opportunity for the PACE organization to ask questions about the engagement letter and audit process, as well as for CMS to emphasize important information within the engagement letter and outline next steps in the audit process.

Document Request Log (DRL) and Element Overview Call – Approximately one week after the engagement letter follow-up call, the CMS audit team conducts a call with the PACE organization to discuss the document request process, requests for additional information, medical records systems access requirements, and the review of elements[3].

Pre-Audit Issue Summary – Within five business days of the date of the engagement letter issuance, the PACE organization is asked to provide a list of all disclosed issues of non-compliance that are relevant to and may be detected during the audit. A disclosed issue is one that has been reported to CMS prior to the date of the audit engagement letter. Issues identified by CMS or the State Administering Agency through ongoing monitoring or other account management and oversight activities, and/or PACE quarterly data reported during or prior to the audit year, are not considered disclosed. PACE organizations must provide a description of each disclosed issue and the status of correction using the Pre-Audit Issue Summary template. The PACE organization's account manager will review the template to validate that disclosed issues were reported to CMS prior to receipt of the audit engagement letter.

PACE Supplemental Questions – Within five business days of the date of the engagement letter issuance, the PACE organization is asked to provide responses to the PACE Supplemental Questions document.

---

[2] Audit engagement letters are typically issued approximately 45 calendar days prior to the start of audit field work. In some instances, CMS may determine that an unannounced audit is necessary. In these instances, the audit engagement letter may not be issued until near or at the start of audit field work.

[3] CMS conducts the DRL and Element overview call with all first-year trial period and routine audits. This call is optional for organizations undergoing second and third-year trial period audits.

Quality and Compliance Documentation Submission – Within 20 business days of the date of the engagement letter, the PACE organization must submit quality improvement plans that were in use during the data collection period, Participant Advisory Committee (PAC) minutes for the data collection period, and documentation demonstrating the measures developed as part of the PO's compliance oversight program to prevent, detect, and correct noncompliance with regulatory requirements and fraud, waste, and abuse.

Monitoring Reports – Within 20 business days of the date of the engagement letter, the PACE organization must submit monitoring reports for 30 participants, selected by CMS, that detail the organization's monitoring and tracking of all services across all care settings that were ordered, approved, or care planned during the data collection period.

Universe Submission – Within 20 business days of the date of the engagement letter, the PACE organization must submit all requested universes to CMS following the instructions in the PACE audit process and data request document.

Universe Analysis – CMS will complete data entry tests on all of the universes to ensure there are no blank entries and data is properly formatted. CMS will also analyze universes throughout the audit for varying compliance standards including, but not limited to, the timeliness of service determination requests and appeals. CMS may request revised universes if data issues are identified. PACE organizations will have a maximum of 3 attempts to provide complete and accurate universes, regardless of when the universes are submitted. When multiple attempts are made, CMS will only use the last universe submitted. If the PACE organization fails to provide accurate and timely universe submissions, CMS will document it in the PACE organization's audit report and this may impact condition classifications.

Audit Sample Selection – CMS selects targeted samples using information submitted by the PACE organization to evaluate during audit field work. Specific sample sizes vary by element and are listed within the PACE audit process and data request document.

Coordination of Audit Field Work – The audit team works with the PACE organization to coordinate, schedule and conduct audit field work; this includes, but is not limited to, coordinating remote access to medical records, scheduling observations, and scheduling meetings with the PACE organization. CMS aims to adhere to the PACE organization's normal business hours when conducting audit field work activities, but may request alternative hours depending on the progress of audit field work.

Phase II: Audit Field Work

PACE audit field work is typically conducted over a period of two weeks. Key milestones for scheduled audits within Phase II include:

Entrance Conference – Audit field work begins with an entrance conference held on the morning of the first day of field work. The audit lead conducts the meeting, reviews the schedule, and discusses expectations for the audit. The PACE organization will also have an opportunity to make a presentation about its organization.

Notification of Sample Selections – Sample selections for the Service Determination Requests, Appeals and Grievances (SDAG) and Personnel elements will be uploaded to HPMS by the audit team two business days before the reviews of the elements begin. Sample selections for medical record samples will be uploaded to HPMS by the audit team one hour before the review of medical records begins. The audit team will work with the PACE organization to select samples for participant observations; therefore, observation samples will be uploaded to HPMS by the audit team once the observation samples are finalized.

Audit Field Work Weeks 1 and 2 – During field work, the audit team will evaluate sample cases and determine whether the samples are compliant with regulatory requirements. In order to determine compliance, auditors may request additional information and documentation. Auditors may also request that organizations provide supporting documentation for non-compliant or potentially non-compliant cases. PACE organizations must upload all information requested by auditors to HPMS.

The first week of the audit field work typically includes a review of the SDAG, Personnel, and Provision of Services elements, but may also include a review of the Compliance and Quality Improvement element. The review of these elements is accomplished through desk reviews, remote access to the PACE organization's medical records, and when applicable, webinars. The first week of audit field work will also include participant and other observation reviews. Observations may be conducted in-person or remotely at PACE centers, Alternative Care Settings, and/or participants' homes. The location(s) of observations will be determined by CMS in collaboration with the PACE organization.

During the second week, the audit team will continue to review samples for elements started, but not completed, during the first week of audit field work. Auditors will also conduct a review of the Compliance and Quality Improvement element if not already completed in week one. The review of the Compliance and Quality Improvement element is typically conducted remotely, via webinar.

CMS may extend the duration of field work beyond two weeks to accommodate holidays or when additional time is needed to complete the review of samples and/or to collect additional information or documentation from the PACE organization.

Daily Debriefs – The purpose of the debrief is to inform PACE organization staff of the status of the audit, review potential conditions of non-compliance identified in sample cases, and address any questions staff may have. Debriefs will be held on a daily basis during the audit field work phase, unless there is no new information, status updates, or questions to discuss or the organization requests not to hold the debrief meeting.

Root Cause Analysis Submissions – A root cause analysis must be submitted, as requested by auditors, for all non-compliance identified during the audit. CMS may also require organizations to submit a completed root cause analysis for any disclosed issue of non-compliance. The PACE organization's root cause analysis must identify the core problem(s) or issue(s) that resulted in non-compliance with regulatory requirements and a description of why the non-compliance

occurred. Root cause analyses are due within 24 to 48 hours of the request (depending on the number requested) and must be uploaded to the HPMS as instructed by CMS. CMS may grant additional time when requested by the organization. CMS will attempt to request all root cause analyses prior to the exit conference; however, CMS reserves the right to make requests after the exit conference has concluded. CMS will review the submission and instruct the PACE organization on next steps for completing an impact analysis, as applicable.

Issuance of Preliminary Draft Audit Report – At the conclusion of the audit field work phase, CMS will issue a preliminary draft audit report to the PACE organization, identifying conditions noted during the audit as of the exit conference. The audit lead issues this report via the HPMS prior to the exit conference. Please note that additional conditions may be added as a result of Root Cause Analyses, Impact Analyses or other submitted data.

Exit Conference – The final day of field work concludes with an exit conference. The audit team will walk through the preliminary conditions of non-compliance with the PACE organization and discuss any outstanding requests for information. During the exit conference, the PACE organization may ask questions about the findings and provide any follow-up information as appropriate. Preliminary conditions of non-compliance are subject to additional review and evaluation after the exit conference when all supporting documentation and requested analyses have been received and evaluated. Classification of conditions will occur once the review and evaluation of all documentation is completed. PACE organizations will have an opportunity to formally respond or provide comments for CMS's consideration during the draft audit report process.

Impact Analysis Submissions – CMS may request impact analyses for conditions identified during the audit in order to determine the scope of non-compliance. CMS may also require organizations to submit a completed impact analysis for any disclosed issue of non-compliance. The impact analysis must identify the participants or personnel subject to or impacted by the issue of non-compliance as instructed by CMS. Within 10 business days of the request or the date of the exit conference (whichever is later), PACE organizations must upload the impact analyses to the HPMS as instructed by CMS. CMS may grant additional time when requested by the organization. CMS may validate the accuracy of the impact analysis submission(s). In the event an impact analysis cannot be produced, is incomplete, or is invalidated, CMS will report that the scope of the non-compliance could not be fully measured and impacted an unknown number of participants/personnel during the audit review period.

Phase III: Audit Analysis and Reporting

Audit analyses and reporting occurs in multiple stages beginning with the findings identified and discussed during the audit field work stage (i.e., daily debriefs, exit conference) and through root cause/impact analysis requests, followed by more formal notification of conditions classified as Immediate Corrective Action Required (ICAR) and issuance of the draft and final reports. Key milestones for scheduled audits within Phase III include:

Root Cause/Impact Analysis Submission and Validation – PACE organizations submit remaining requested root cause and impact analyses. Audit team members review and analyze submitted impact analyses to determine the effect of non-compliance. If CMS believes that one or more impact analyses may be incomplete or inaccurate, CMS may validate the accuracy of the impact analysis submission(s) and may require the organization to submit additional case files or provide access to additional participant medical records.

Condition Classification – Upon receipt of all audit documentation, auditors meet with the PACE Audit Consistency Team (PACT). The PACT serves as subject matter experts for PACE and audit policy and ensures consistency in classification of audit conditions across all audits in accordance with the following definitions:

- ***Immediate Corrective Action Required (ICAR) –*** An ICAR is a deficiency that requires prompt correction prior to the issuance of the final report. These conditions of non-compliance result in a lack of access to care and/or services, may pose an immediate threat to participant health and safety, and/or result in harm or the potential for harm. Situations that restrict, hinder, or limit a participant's ability to request or advocate for care and/or services are considered a lack of access to care or services[4].

- ***Corrective Action Required (CAR) –*** A CAR is a deficiency that must be corrected, but the correction can wait until the final audit report is issued. These issues may impact participants, but are not of a nature that immediately affects their health and safety or their ability to advocate for care and/or services. Generally, they involve deficiencies with respect to lacking or inadequate policies and procedures, systems, internal controls, training, operations, or staffing.

- ***Observations –*** Observations are conditions of non-compliance that do not require submission of a corrective action plan based on the nature of the deficiency and why the deficiency occurred. For example, conditions may be classified as observations when only one instance of non-compliance is identified and the non-compliance occurred as a result of human error. Although CMS does not require the submission of corrective action plans for observations, CMS does expect PACE organizations to ensure the non-compliance is addressed and corrected.

Referral for Enforcement Action – Conditions noted in the audit may be referred to the Division of Compliance Enforcement (DCE). DCE will conduct an independent review of audit documentation to determine if an enforcement action (Civil Money Penalty, sanction, or contract termination) is warranted.

Notification of Immediate Corrective Action Required (ICAR) Conditions – If one or more conditions are classified as an ICAR, the PACE organization will receive notification and prompt corrective action must be implemented in order to remediate non-compliant activity and prevent

[4] If CMS determines that a disclosed issue was promptly identified, corrected, and the risk to participants has been mitigated, CMS may not apply the Immediate Corrective Action Required classification to that condition. CMS may require organizations to submit a completed root cause analysis and/or impact analysis for any disclosed issue of non-compliance.

future non-compliance. This notification typically is issued in advance of the draft audit report, but may occur with the draft audit report. PACE organizations are required to submit Corrective Action Plans describing the actions taken to remediate non-compliance within three business days of being informed of the ICAR condition.

Draft Audit Report Preparation and Issuance to the PACE Organization – CMS prepares a draft audit report (inclusive of condition classifications) with a target for issuance between 60 and 90 calendar days from the date of the last data submission received from the PACE organization.

Draft Report Response – The PACE organization has 10 business days to respond to the draft audit report with comments to CMS. This is an organization's opportunity to request reconsideration of a condition or classification. CMS reviews and responds to any comments the PACE organization submits in the HPMS and determines if the comments warrant a change in the final audit report.

Issuance of the Final Audit Report – CMS aims to issue the final audit report between 15 and 30 calendar days from receipt of the PACE organization's comments to the draft audit report. The final report contains the final classification of conditions noted during the audit. There is no additional opportunity to comment on the conditions of non-compliance after this report is issued.

Audit Feedback – Following issuance of the final audit report, CMS will send PACE organizations an optional audit survey. CMS will use feedback collected from the survey to improve the PACE audit process.

Phase IV: Audit CAPs and Close Out

The final phase of the PACE audits occurs over a period of approximately 60 to 90 days. Once the final audit report is issued, PACE organizations develop, implement, and monitor corrective action plans. Key milestones for scheduled audits within Phase IV include:

Non-ICAR Corrective Action Plan (CAP) Submission – PACE organizations have 10 business days from the issuance of the final audit report to submit CAPs associated with conditions classified as Corrective Action Required.

CAP Review and Acceptance – Upon receipt of the CAPs, CMS performs a reasonableness review and notifies the PACE organization of either CAP acceptance or the need for additional information. CMS continues the reasonableness review process until it deems all CAPs acceptable.

CAP Implementation and Release – CMS requires that PACE organizations undertake correction of conditions noted in the final audit report. The PACE organization's account manager will provide technical assistance and education to help the organization ensure that their implemented corrective actions will effectively address non-compliance. This may include collection and review of documentation submitted by the organization. Corrective action plans

will be released 60 days after CAPs acceptance by CMS with the expectation that PACE organizations will have fully implemented those corrective action plans by that time.

Audit Close Out – Once CAPs are released, CMS will close the audit and send an audit close out letter to the PACE organization. The PACE organization should continue to monitor the implemented corrective actions to ensure and maintain full compliance with CMS requirements.