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New York State

Medicaid Managed Long-Term Care

2021 External Quality Review Annual Technical Report

April 2023

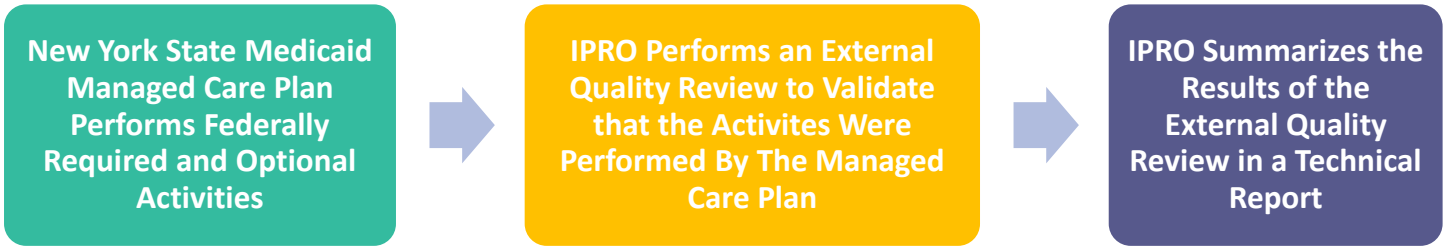
Prepared on behalf of:
The New York State Department of Health
Office of Quality and Patient Safety

Table of Contents

List of Tables

About This Report

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual, external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. The New York State Department of Health (hereafter referred to as the Department of Health) contracted with IPRO, an external quality review organization, to conduct the 2021 external quality review of the managed care plans that comprised New York's Medicaid Managed Long-Term Care program. The results of this review are summarized in this report.



This external quality review technical report focuses on two federally required activities (performance improvement projects and review of compliance with Medicaid standards) and one optional activity (quality-of-care survey) that were conducted between January 1, 2021 and December 31, 2021, or measurement year 2021.

Table 1: Medicaid Managed Long-Term Care Activities Performed for 2021

What Did the Department of Health Do?	What Did the Medicaid Managed Long-Term Care Plans Do?	What Did IPRO Do?
Required all Managed Long-Term Care plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects.	Conducted performance improvement projects on improving transitions of care, or on reducing emergency department and hospitalization utilization.	Evaluated how the Managed Long-Term care plans conducted performance improvement projects.
Required all Managed Long-Term Care plans to comply with federal and state Medicaid standards; and conducted an evaluation to determine Medicaid Managed Long-Term Care plan compliance with Medicaid standards.	Presented evidence of compliance with Medicaid standards to the Department of Health.	Reviewed the results of an evaluation of Managed Long-Term Care plan compliance with Medicaid standards.
Sponsored a quality-of-care survey, conducted by IPRO, for all Managed Long-Term Care plans.	Used these findings in planning future activities to address or enhance member experience.	Conducted a survey on member experience with Managed Long-Term Care plans.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. *Title 42 Code of Federal Regulations Section 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review of contracted managed care plans. States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services.[1] 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[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

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

To comply with *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 2021 external quality review of the Long-Term Care managed care plans that are part of New York's Medicaid managed care program.

2021 External Quality Review

This external quality review technical report focuses on two federally required activities (validation of performance improvement projects and review of compliance with Medicaid standards) and one optional activity (quality-of-care survey) that were conducted for measurement year 2021. The required validation of performance measures activity was not performed for measurement year 2021 because the Department of Health was not able to calculate Managed Long-Term Care quality measures due to a pandemic related reassessment moratorium.[5]

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[1] The Centers for Medicare and Medicaid Services website: https://www.cms.gov/.

[2] prepaid inpatient health plan.

[3] prepaid ambulatory health plan.

[4] primary care case management.

[5] In response to COVID-19 outbreak and state disaster emergency declared by Executive Order No. 202, the Department of Health issued guidance on March 18, 2020, and updated on April 8, 2020, entitled *COVID-19 Guidance for the Authorization of Community Based Long-term Services and Supports Covered by Medicaid*. This guidance placed a moratorium on community health assessments. The Department of Health rescinded this guidance on July 26, 2021.

IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[6] published in October 2019. The external quality review activities and corresponding protocols are described in Table 2.

Table 2: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed Medicaid Managed Long-Term 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) *This activity was not performed for measurement year 2021 due to COVID-19 restrictions.*	Protocol 2	When available, IPRO reviews data reported by the Medicaid Managed Long-Term Care plans through the Uniform Assessment System for New York. The Uniform Assessment System for New York is a web-based tool used by Medicaid Managed Long-Term Care plans to conduct clinical assessments at enrollment and at six-month intervals thereafter.
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 Medicaid Managed Long-Term Care plan compliance with Medicaid standards. Specifically, this review assessed compliance with *Code of Federal Regulations Part 438 Subpart D*, *Code of Federal Regulations 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 Article 44* and *Article 49*, and *New York State Official Compilation of Codes, Rules, and Regulations Part 98-Managed Care Organizations*.
Activity 6. Administration of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO administered a survey, on behalf of the Department of Health, to evaluate member experience with New York's Medicaid Managed Long-Term Care program, managed care plans, and providers.

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

[6] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

New York State Medicaid Managed Care Program and Medicaid Quality Strategy

History of the New York State Medicaid Managed Care Program

The New York State Medicaid managed care program began in 1997 when New York State received approval from the Centers for Medicare & Medicaid Services to mandatorily enroll Medicaid members in a managed care program through a Section 1115 Demonstration Waiver.[7] Section 1115 of the Social Security Act allows for "demonstration projects" to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The New York State Section 1115 Demonstration Waiver project 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 State Medicaid 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 the New York State Medicaid program and participating managed care plans. The Department of Health performs periodic reviews of its Medicaid 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 monitoring and ongoing quality improvement. The Department of Health updates the Medicaid quality strategy as needed, but no less than once every three years.

New York State's 2020–2022 Medicaid Quality Strategy[8] 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 quality strategy aims and corresponding goals are:

- Triple Aim 1: Improved Population Health
  Goal 1: Improve maternal health

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

[8] 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.

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 Medicaid quality strategy measurement plan, including metric names, Medicaid 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 re-measurement rates are from measurement year 2020 (January 1, 2020 through December 31, 2020), and year 2 re-measurement rates are from measurement year 2021 (January 1, 2021 through December 31, 2021).

Table 3: New York State Medicaid Quality Strategy Metrics and Performance Rates

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	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%	84%
	Maternal mortality rate per 100,000 live births (All New York State)	18.9[1]	18.1[3]	19.3[4]	16.0
Goal 2: Ensure a healthy start	Lead screening in children (Mainstream Medicaid, Child Health Plus)	89%	87%	81.18%	90%
	Members receiving oral health services by a non-dentist provider (Mainstream Medicaid)	0.8%	1.25%	1.38%	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%	94%
	Asthma medication ratio, 5-18 years (Mainstream Medicaid, Child Health Plus)	66%	68%	65.47%	67%
	Asthma medication ratio, 19-64 years (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	55%	49%	49.59%	56%
	Controlling high blood pressure (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	67%	56%	64.82%	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%	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	To Be Determined

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
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 (Subset of high school students in New York State)	26.4%	Non-Survey Year	2021 Data Scheduled for 2023 Release	23.6%
	High school students reporting binge drinking on at least one day during the past 30 days (Subset of high school students in New York State)	12.7%	Non-Survey Year	2021 Data Scheduled for 2023 Release	10.8%
	High school students reporting current use of marijuana on at least one day during the past 30 days (Subset of high school students in New York State)	19.1%	Non-Survey Year	2021 Data Scheduled for 2023 Release	17.1%
	Adult alcohol binge drinking (All New York State)	25.48%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	24.0%
	Adult use of marijuana (All New York State)	10.05%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	9.14%
	Adult use of cocaine (All New York State)	2.82%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	2.37%
	Adult use of heroin (All New York State)	0.3%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	0.17%
	Adult use of illicit drug use other than marijuana (All New York State)	3.42%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	2.94%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
	Medicaid smoking prevalence (Mainstream Medicaid, Fee-For-Service)	23%	22.9%	19.1%	21.4%
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%	38%
	Initiation of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	50%	50%	48.99%	51%
	Engagement of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	20%	20%	18.68%	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%	70%
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 (Managed Long-Term Care)	2.76	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%	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%
	Appropriate treatment for upper respiratory infection, 18-64 Years (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	72%	75%	81.18%	73%

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

To achieve the overall objectives of the New York State Medicaid managed care program and to ensure New York Medicaid recipients have access to the highest quality of health care, the New York State Medicaid 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 Medicaid 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 has expanded coverage of telehealth services to include:
    - Additional originating and distant sites
    - Additional telehealth applications (store-and-forward telemedicine and remote patient monitoring)
    - Additional practitioner types
- Provide safe, reliable transportation through contracts with two professional transportation managers across five geographic regions to administer Medicaid's transportation benefit.
- The Department of Health strongly encourages 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. This program has a formal evaluation plan and state-contract independent evaluator. The final Summative Evaluation is currently being completed, with preliminary results not yet published, but demonstrating significant progress was made towards the achievement of targets.

IPRO's Assessment of the New York State Medicaid Quality Strategy

The 2020-2022 NYS Medicaid quality strategy generally meets the requirements of *42 Code of Federal Regulation 438.340 Managed Care State Quality Strategy,* and acts as a framework for the managed care plans to follow while aiming to achieve improvements in the quality of, timeliness of, and access to care. Goals and aims are clearly stated and supported by well-designed interventions, and methods for measuring and monitoring managed care plan progress toward improving health outcomes incorporate external quality review activities. The strategy includes several activities focused on quality improvement that are designed to build an innovative, well-coordinated system of care that addresses both medical and non-medical drivers of health such as performance improvement projects, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

Between measurement year 2020 and measurement year 2021, statewide performance met or exceeded targets in areas related to the reduction of smoking prevalence, initiation of treatment for substance abuse, treatment for upper respiratory infection, member experience with health plan assistance managing chronic conditions, and the reduction of preventable admissions. Further findings from the 2021 external quality review activities highlight managed care plan commitment to achieving the goals of the New York State Medicaid quality strategy.

Opportunities to improve health outcomes exist statewide. As evidenced by measurement year 2021 performance, continued attention to population health and quality of care, is appropriate.

Opportunities to strengthen the effectiveness of the New York State Medicaid quality strategy also exist. The Department of Health is unable to trend its performance from baseline for nine quality strategy metrics due to data collection limitations. Additionally, there are two metrics for which no data has been captured and no target has been established.

Recommendations to the New York State Department of Health

Per *42 Code of Federal Regulation 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 enrollees. As such, IPRO recommends the following to the Department of Health:

- To fully comply with *42 Code of Federal Regulation 438.340(b)(1)*, the Department of Health should consider updating the 2020-2022 Medicaid quality strategy to include New York State specific network adequacy and availability of services standards for Medicaid managed care plans.
- 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 include 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 care plans managing healthcare services for New Yorkers who are eligible for long-term care services: Medicaid Advantage Plus, Partial Capitation, and Program of All-Inclusive Care for the Elderly. In 2021, there were 13 approved Medicaid Advantage Plus managed care plans but two of the managed care plans (Integra Synergy and MetroPlus Health Ultracare) did not enroll members that year; 25 Partial Capitation managed care plans; and 9 Program of All-Inclusive Care for the Elderly managed care plans. Descriptions of the Medicaid Managed-Long Term Care plan types are in Table 4.

Table 4: Medicaid Managed Long-Term Care Plan Types

Medicaid Managed Long-Term Care Plan Types
Medicaid Advantage Plus
Managed care 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. The Medicaid Advantage Plus plan receives 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
Medicaid capitation payments are provided to the managed care plan to cover the costs of long-term care and selected ancillary services. Ambulatory care and inpatient services are paid for by Medicare if the member is dually eligible for both Medicare and Medicaid, or by Medicaid if the member is not Medicare eligible. Beneficiaries who are only eligible for Medicaid generally receive non-Managed Long-Term Care services through Medicaid Fee-For-Service, as members in Partial Capitation Managed Long-Term Care plans are ineligible to join a traditional Medicaid managed care plan. The minimum age requirement for eligibility is 18 years of age. Medicaid members receiving Fee-For-Service long-term care services are mandatorily required to enroll in a Partial Capitation managed care plan.
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. The managed care plan is responsible for directly providing or arranging all primary, inpatient hospital, and long-term care services needed by the member. The managed care plan is approved by the Centers for Medicare & Medicaid Services.

Table 5 displays enrollment data for each Medicaid 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 2021.

Table 5: Medicaid Managed Long-Term Care Profiles

Medicaid Managed Long-Term Care Plan	Enrollment as of 12/2021
Medicaid Advantage Plus	**30,256**
AgeWell New York Advantage Plus (AgeWell)	62
Centers Plan for Medicaid Advantage Plus (Centers Plan)	705
Elderplan, Inc. MAP (Elderplan)	2,813
Empire Blue Cross Blue Shield HealthPlus Duals Plus (Empire BCBS HealthPlus)	133
Fidelis Medicaid Advantage Plus (Fidelis Care)	185
Hamaspik Inc. (Hamaspik)	177
Healthfirst CompleteCare (Healthfirst)	20,140
RiverSpring MAP (RiverSpring)	79
Senior Whole Health of New York MAP (Senior Whole Health)	110
VillageCareMAX Medicare Total Advantage (VillageCare)	2,829
VNS Health Total (VNS Health)	3,023
Partial Capitation	**245,571**
Aetna Better Health (Aetna)	5,687
AgeWell New York (AgeWell)	13,167
ArchCare Community Life (ArchCare)	4,651
Centers Plan for Healthy Living (Centers Plan)	46,943
Elderwood Health Plan (Elderwood)	1,034
Empire Blue Cross Blue Shield HealthPlus MLTC (Empire BCBS HealthPlus)	4,981
EverCare Choice (EverCare)	954
Extended MLTC, LLC (Extended MLTC)	5,734
Fallon Health Weinberg-MLTC (Fallon Health)	874
Fidelis Care at Home (Fidelis Care)	18,750
Hamaspik Choice, Inc. (Hamaspik)	2,021
HomeFirst, a product of Elderplan, Inc. (Elderplan)	13,721
iCircle Care (iCircle)	3,600
Integra MLTC, Inc. (Integra)	40,902
Kalos Health	578
MetroPlus MLTC (MetroPlus)	1,397
Montefiore Diamond Care (Montefiore)	1,486
Nascentia Health (Nascentia)	3,336
Prime Health Choice, LLC (Prime Health)	571
RiverSpring at Home (RiverSpring)	15,426
Senior Health Partners A Healthfirst Company (Senior Health Partners)	10,275
Senior Network Health, LLC (Senior Network Health)	376
Senior Whole Health of New York MLTC (Senior Whole Health)	13,526
VillageCareMAX (VillageCare)	13,787
VNS Health MLTC (VNS Health)	21,794
Program of All-Inclusive Care for the Elderly	**5,840**
ArchCare Senior Life (ArchCare)	705
Catholic Health-LIFE (Catholic Health)	256
CenterLight Healthcare PACE (CenterLight)	2,934

Medicaid Managed Long-Term Care Plan	Enrollment as of 12/2021
Complete Senior Care	130
Eddy SeniorCare	306
Fallon Health Weinberg-PACE (Fallon Health)	126
Independent Living for Seniors dba ElderONE (ElderONE)	712
PACE CNY	532
Total Senior Care, Inc. (Total Senior Care)	139

Data Sources: New York State Department of Health Managed Long-Term Care Plan Directory, Revised October 2022. 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 2021. Website: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2021/docs/en12_21.pdf

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
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans work on projects to improve the value or quality of health care for New Yorkers. These types of projects are called performance improvement projects. The New York Medicaid managed care plans are required to conduct a performance improvement project every year. The Department of Health and the managed care plans select the topics for the performance improvement project.

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 care plans. IPRO decides if the projects make sense and if the results are accurate.

In 2021, the managed care plan performance improvement project topics were emergency department and hospitalization utilization reduction or transitions of care.

2021 Performance Improvement Projects Summary

Validation Process

- Does the report have a topic, identify a population, have a clear and meaningful focus?
- There is a review of the managed care plan's sampling methods, data collection, and the results.
- Are the improvement strategies appropriate? Was there an improvement?

Validation Results

- All Medicaid Managed Long-Term Care plans passed validation.

Performance Improvement Project Results

- Of the 18 MLTC plans that aimed to reduce emergency department and hospitalization use:
  - 6 MLTC plans exceeded their goal rate for increasing timely post-discharge assessments
  - 7 MLTC plans exceeded their goal rate for sending timely inpatient discharge information to the member
  - 5 MLTC plans exceeded their goal rate for reducing the number readmissions resulting from an inpatient discharge
- Of the 23 MLTC plans that aimed to reduce emergency department and hospitalization use:
  - 10 MLTC plans exceeded their goal rate for reducing potentially avoidable hospitalizations
  - 7 MLTC plans exceed their goal rate for reducing hospital stays
  - 4 MLTC plans exceeded their goal rate for reducing emergency room visits

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(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 Medicaid 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 2019 and continuing through 2021, the Medicaid Managed Long-Term Care plans were required to conduct one of two performance improvement projects: Emergency Department and Hospitalization Utilization Reduction or Transitions of Care.

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 Transitions of Care and Emergency Department and Hospitalization Utilization Reduction performance improvement projects.

While interventions were managed care plan-specific, the performance improvement project focus areas were consistent across the Medicaid Managed Long-Term Care plans that selected the same topic. The Transitions of Care performance improvement project aimed to decrease the occurrence of hospital readmissions within 30 days of discharge by improving transitions of care processes. The Emergency Department and Hospitalization Utilization Reduction performance improvement project aimed to decrease member use of emergency room services for non-emergency events, redirect members to condition-appropriate settings of care, and to reduce the occurrence of potentially avoidable hospitalizations.

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 that interventions impact the maximum volume of 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 was used) for validity and proper technique, and review of the sample to ensure it is representative of the managed care plan's enrollment and generalizable to the managed care plan's total population.
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 the review of the listed elements, the review findings were considered to determine whether the performance improvement project outcomes should be accepted as valid and reliable. The element is determined to be "met" or "not met." Due to significant data collection limitations resulting from the moratorium on reassessments, IPRO was unable to make determinations for elements 9 and 10 for all Medicaid Managed Long-Term Care plans that conducted a transitions of care performance improvement project.

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 of the performance improvement project results was at risk.
- The validation findings generally indicate that the credibility of 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 or inconsistency 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 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 2021 external quality review, IPRO reviewed managed care plan performance improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of each Medicaid 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. A summary of the validation assessments is in Table 6.

Performance indicator rates related to transitions of care are in Table 7; and rates related to emergency department and hospitalization reduction are in Table 8.

AgeWell, Centers Plan, and VillageCare did not conduct performance improvement projects for the Medicaid Advantage Plus program for measurement year 2021 due to low enrollment. Hamaspik did not conduct a performance improvement project for the Medicaid Advantage Plus program for measurement year 2021 due to a mid-year operational start in 2021 and low enrollment.

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

Table 6: Performance Improvement Project Validation Findings, Measurement Year 2021

Medicaid Managed Long-Term Care Plan Performance Improvement Project Validation Elements										
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[1]	Achieved Sustained Improvement[1]
Medicaid Advantage Plus										
AgeWell[2]	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project
Centers Plan[2]	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project
Elderplan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Hamaspik[3]	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project
Healthfirst	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
RiverSpring	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Senior Whole Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VillageCare[2]	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project	No Project
VNS Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Partial Capitation										
Aetna	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
AgeWell	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
ArchCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Centers Plan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Elderplan	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Elderwood	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
EverCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine

Medicaid Managed Long-Term Care Plan Performance Improvement Project Validation Elements										
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[1]	Achieved Sustained Improvement[1]
Extended MLTC	Met	Met	Met	Met	Met	Met	Met	Met	Unable to Determine	Unable to Determine
Fallon Health	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Hamaspik	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
iCircle	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Integra	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Kalos Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Montefiore	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Nascentia	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Prime Health	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
RiverSpring	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Senior Health Partners	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Senior Network Health	Met	Met	Met	Met	Met	Met	Met	Met	Unable to Determine	Unable to Determine
Senior Whole Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VillageCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
VNS Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Program of All-Inclusive Care for the Elderly										
ArchCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Catholic Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine

Medicaid Managed Long-Term Care Plan Performance Improvement Project Validation Elements										
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[1]	Achieved Sustained Improvement[1]
CenterLight	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Complete Senior Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Eddy SeniorCare	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
ElderONE	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Fallon Health	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
PACE CNY	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Unable to Determine	Unable to Determine
Total Senior Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met

[1] When performance improvement was reported by the managed care plan, IPRO determined that the improvement was real and sustained based on its validation of the performance improvement project methodology; the "met determination" does not mean that all performance indicators demonstrated improvement.

[2] AgeWell, Centers Plan, and VillageCare did not conduct performance improvement projects for the Medicaid Advantage Plus program for measurement year 2021 due to low enrollment.

[3] Hamaspik did not conduct a performance improvement project for the Medicaid Advantage Plus program for measurement year 2021 due to a mid-year operational start in 2021 and low enrollment.

Table 7: Performance Improvement Project Indicator Rates for the Transitions of Care Topic, Measurement Year 2021

Medicaid Managed Long-Term Care Plan Transitions of Care Rates			
Managed Care Plan	Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]
Medicaid Advantage Plus			
RiverSpring	60.00%	Not Available	30.00%
VNS Health	25.74%	Not Available	12.38%
Partial Capitation			
AgeWell	55.29%	Not Available	7.19%
Centers Plan	67.60%	Not Available	19.80%
EverCare	84.88%	Not Available	23.68%
Extended MLTC	81.50%	Not Available	24.25%
iCircle	100.00%	Not Available	10.34%
Integra	94.15%	Not Available	14.62%
RiverSpring	54.61%	Not Available	24.10%
Senior Network Health	82.14%	Not Available	22.14%
VNS Health	16.30%	Not Available	11.10%
Program of All-Inclusive Care for the Elderly			
ArchCare	90.98%	Not Available	18.03%
Catholic Health	96.30%	Not Available	11.54%
CenterLight	83.74%	Not Available	14.56%
Complete Senior Care	100.00%	Not Available	19.15%
Eddy SeniorCare	83.95%	Not Available	21.72%
ElderONE	88.64%	Not Available	21.36%
PACE CNY	97.82%	Not Available	18.53%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Table 8: Performance Improvement Project Indicator Rates for the Emergency Department and Hospitalization Utilization Reduction Topic, Measurement Year 2021

Managed Care Plan Emergency Department and Hospitalization Utilization Rates			
Managed Care Plan	Percentage of Members Without an Emergency Room Visit in the Last 90 Days	Percentage of Members Without a Hospital Stay in the Last 90 Days	Potentially Avoidable Hospitalizations Rate[1]
Medicaid Advantage Plus			
Elderplan	94.78%	89.86%	2.56
Empire BCBS HealthPlus	0.00%	93.59%	0.42
Fidelis Care	92.13%	88.98%	5.00
Healthfirst	92.14%	78.61%	3.30
Senior Whole Health	97.92%	79.17%	3.54
Partial Capitation			
Aetna	95.61%	89.58%	Not Available
ArchCare	93.47%	86.65%	3.86
Elderplan	94.14%	86.32%	Not Available
Elderwood	77.54%	80.51%	Not Available
Empire BCBS HealthPlus	95.58%	91.88%	2.24
Fallon Health	87.35%	93.29%	4.08
Fidelis Care	91.06%	81.14%	3.31
Hamaspik	94.87%	95.65%	2.72
Kalos Health	81.73%	84.70%	2.98
MetroPlus	Not Available	Not Available	0.02
Montefiore	69.41%	76.45%	3.98
Nascentia	86.34%	78.42%	4.52
Prime Health	89.21%	86.12%	5.38
Senior Health Partners	92.32%	80.57%	3.29
Senior Whole Health	93.64%	74.64%	2.86
VillageCare	95.65%	82.67%	2.74
Program of All-Inclusive Care for the Elderly			
Fallon Health	96.08%	91.50%	2.69
Total Senior Care	80.66%	93.20%	1.75

[1] A lower rate indicates better performance.

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
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans collect information on the health status of New Yorkers on Medicaid and the services they receive. They share this information with the Department of Health and its partners in many ways. One way is through performance measures. A performance measure describes health care and health status using numbers. These numbers are percentages or rates. Performance measure rates often use the "%" symbol.

The information used to calculate the performance measure rates must be accurate. The information must also be complete. The managed care plans check that the information is accurate and complete. This is called "validation." The Department of Health uses this information to calculate performance measure rates. The performance measure rates must be accurate. They must also be complete. The Department of Health validates that the performance measure rates are accurate and complete.

Validation Process

- Can managed care plans collect, store, analyze and report health information?
- Are reporting practices and performance measure specifications compliant?
- Is each performance measure accurate? Is it complete?

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.

Due to COVID-19, the Medicaid Managed Long-Term Care plans were unable to report performance data for 2021.

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

Technical Summary – Validation of Performance Measures

Performance measure results are not available for the period under review. The Department of Health was not able to calculate Medicaid Managed Long-Term Care quality measures that are based on community health assessments due to a moratorium that was in place for over 17 months. A moratorium on community health reassessments was put in place by the Department of Health in response to COVID-19.

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 measure and report to the state on its performance using the standard measures required by the state.

The Uniform Assessment System for New York is a web-based clinical assessment tool based on a uniform data set, which standardizes and automates needs assessments for home- and community-based programs. Some Uniform Assessment System for New York elements are used as performance measures in lieu of Healthcare Effectiveness Data and Information Set (HEDIS®[9])/Quality Assurance Reporting Requirements data due to them not being available for Medicaid Managed Long-Term Care plans. Data are immediately available to users during and upon completion of the community health assessment. The Medicaid Managed Long-Term Care plans use the Uniform Assessment System for New York to conduct assessments at enrollment and at six-month intervals thereafter. The Department of Health makes the aggregate data available to the Medicaid Managed Long-Term Care plans via a Uniform Assessment System for New York data exchange and through performance measure reports.

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. Due to COVID-19, assessment data for 2021 were not available for inclusion in this report.

Technical Methods of Data Collection and Analysis

The Medicaid Managed Long-Term Care plans conduct the community health assessments either directly with their own nursing staff, or through subcontractors. The Department of Health requires that these community health assessments be completed by a registered nurse. The data are submitted electronically to the Department of Health through the Uniform Assessment System for New York. Each year, the community health assessment submissions to the Uniform Assessment System for New York are used to create two static assessment files. One contains the most recent community health assessment for enrollees in each Medicaid Managed Long-Term Care plan from January through June. The second contains the most recent community health assessment for enrollees in each Medicaid Managed Long-Term Care plan from July through December. These two files are used to describe and evaluate Medicaid Managed Long-Term Care plan performance.

Table 9 displays health assessment categories and corresponding indicators as defined in the Uniform Assessment System for New York.

[9] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the health care quality.

Table 9: Uniform Assessment System for New York Community Health Assessment Categories and Indicators

Assessment Category/Indicator	Indicator Description
Overall Functioning and Activities of Daily Living	
Locomotion	Percentage of members who moved between locations on the same floor independently, with setup help, or under supervision.
Bathing	Percentage of members who took a full-body bath/shower independently, with setup help, or under supervision.
Dressing Upper Body	Percentage of members who dressed and undressed their upper body independently, with setup help, or under supervision.
Dressing Lower Body	Percentage of members who dressed and undressed their lower body independently, with setup help, or under supervision.
Toileting	Percentage of members who used the toilet room (or commode, bedpan, urinal) independently, with setup help, or under supervision.
Eating	Percentage of members who ate and drank (including intake of nutrition by other means) independently or with setup help only.
Continence, Neurological, and Behavioral Status	
Urinary Continence	Percentage of members who were continent, had control with any catheter or ostomy, or were infrequently incontinent of urine.
Bowel Continence	Percentage of members who were continent, had bowel control with ostomy, or were infrequently incontinent of feces.
Cognitive Functioning	Percentage of members whose Cognitive Performance Scale 2 indicated intact functioning. The Cognitive Performance Scale 2 is a composite measure of cognitive skills for daily decision making, short-term memory, procedural memory, making self-understood, and how an individual eats and drinks.
Living Arrangements and Emotional Status	
No Anxious Feelings	Percentage of members who reported no anxious, restless, or uneasy feelings.
No Depressive Feelings	Percentage of members who reported no sad, depressed, or hopeless feelings.
Effectiveness of Care	
Pain Controlled	Risk-adjusted percentage of members who did not experience uncontrolled pain.
Eye Exam	Percentage of members who received an eye exam in the last year.
Hearing Exam	Percentage of members who received a hearing exam in the last two years.
No Falls with Injury	Risk-adjusted percentage of members who did not experience falls that resulted in major or minor injury in the last 90 days.
Dental Exam	Percentage of members who received a dental exam in the last year.
Influenza Vaccination	Percentage of members who received an influenza vaccination in the last year.

Description of Data Obtained

Due to COVID-19, assessment data for 2021 were not available for inclusion in this report.

Comparative Results

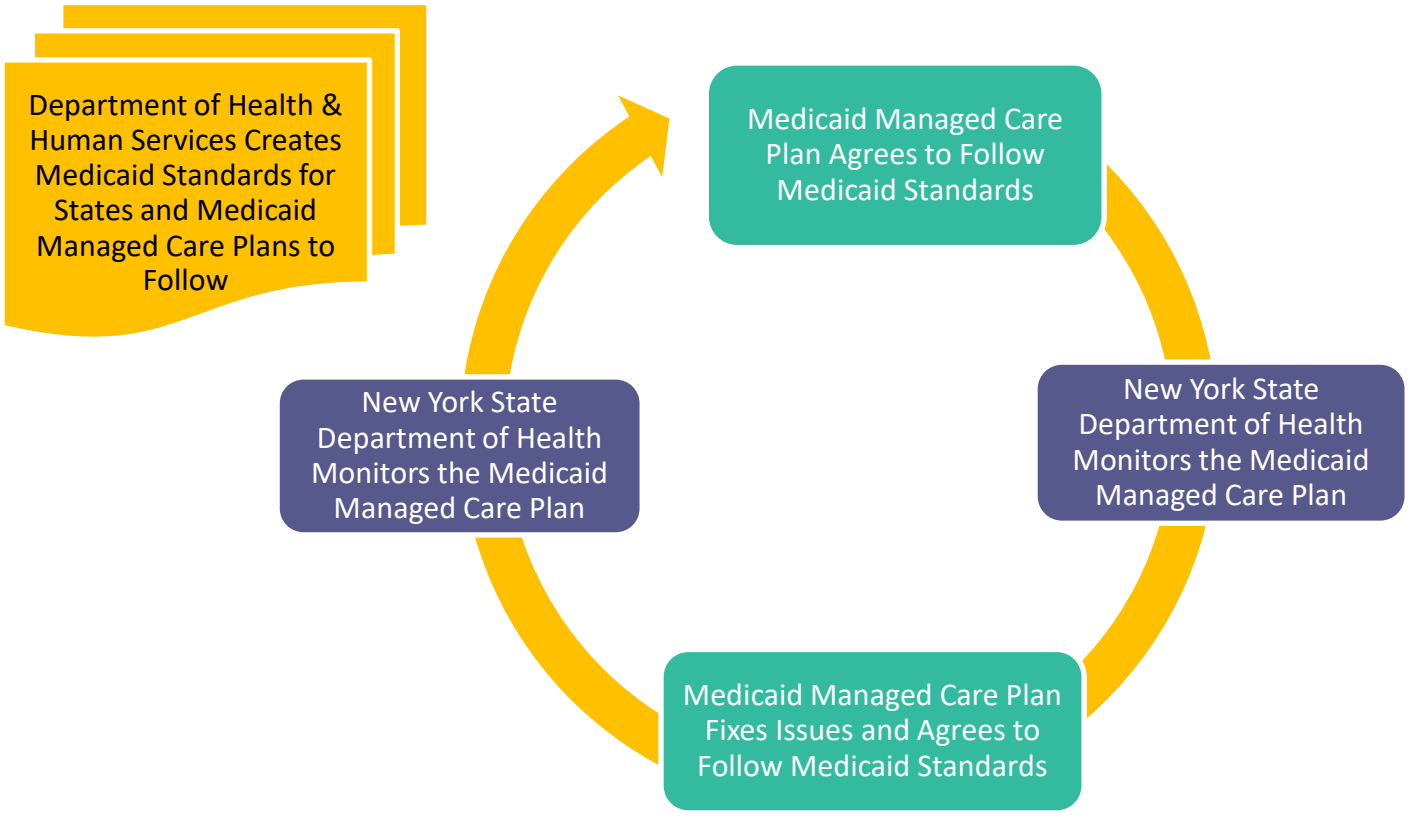
Due to COVID-19, assessment data for 2021 were not available for inclusion in this report.

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**
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

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 Medicaid managed care plans follow the Medicaid standards. The Department of Health continuously monitors the Medicaid managed care plans. The main way that the New York Medicaid managed care plans are monitored is through the Managed Care Operational Survey. 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.



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 of *Title 42 Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards* and the standards of *Title 42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program* is a mandatory external quality activity. 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 Medicaid Managed Long-Term care plans are in compliance with federal and state Medicaid requirements and the standards of *Code of Federal Regulations Part 438 Subpart D*, *Code of Federal Regulations 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 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[10]. 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 Medicaid Long-Term Care plans and instead extended response times for the existing plans and existing focused surveys.

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.

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

Technical Methods of Data Collection and Analysis

The Department of Health's primary method for Medicaid 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 Medicaid 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 covers 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 Medicaid 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 Care Operational Survey and includes the following:

- An evaluation of the Medicaid 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 Medicaid 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 Medicaid 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 Medicaid Managed Long-Term Care plan, along with a request for pertinent documents and data reports to serve as evidence of Medicaid 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 Medicaid 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 Medicaid 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 Medicaid Managed Long-Term Care plan staff, the Department of Health survey team, and any other necessary Department of Health staff. The Medicaid 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 Medicaid Managed Long-Term Care plan responses/clarifications were reviewed, a statement of deficiency detailing the survey results was issued to the Medicaid Managed Long-Term Care plan. For areas of non-compliance, the Medicaid 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.

Description of Data Obtained

To evaluate Medicaid 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 Medicaid Managed Long-Term Care plan, while the *Operational Plan Deficiencies Report* included detailed information on the areas of noncompliance for each Medicaid Managed Long-Term Care plan. Both reports reflected the date of when the results were issued by the Department of Health to the Medicaid Managed Long-Term Care plan, the corrective action plan submission date, and the corrective action plan approval date.

Comparative Results

When available, Medicaid Managed Long-Term Care plan results for the Operational Survey activities are presented by federal Medicaid standards in Table 10, Table 11, and Table 12. In these tables, a "C" indicates that the Medicaid Managed Long-Term Care plan was in compliance with all standard requirements and an "NC" indicates that the Medicaid 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 Medicaid Managed Long-Term Care Plan-Level Reporting section of this report.

Table 10: Medicaid Advantage Plus Managed Care Plan Compliance Survey Results

Managed Care Plan	Activity	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
AgeWell	2019-2021 Not Yet Scheduled											
Centers Plan	2019-2021 Not Yet Scheduled											
Elderplan	2019-2021 Not Yet Scheduled											
Empire BCBS HealthPlus	2019-2021 Not Yet Scheduled											
Fidelis Care	2019-2021 Not Yet Scheduled											
Hamaspik	2019-2021 Not Yet Scheduled											
Healthfirst	2019 Comprehensive	NC	NC	NC	NC	C	C	C	C	C	C	C
RiverSpring	2019-2021 Not Yet Scheduled											
Senior Whole Health	2019-2021 Not Yet Scheduled											
VillageCare	2019-2021 Not Yet Scheduled											
VNS Health	2019-2021 Not Yet Scheduled											

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 11: Partial Capitation Managed Care Plan Compliance Survey Results

Managed Care Plan	Activity	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	NC	NC	NC	C	C	C	C	NC	C
AgeWell	2019-2021 Not Yet Scheduled											
ArchCare	2019-2020 Comprehensive	C	C	NC	NC	NC	C	NC	NC	C	NC	C
Centers Plan	2021 Comprehensive	C	C	C	C	NC	C	NC	C	C	NC	C
Elderplan	2019-2021 Not Yet Scheduled											
Elderwood	2019-2021 Not Yet Scheduled											
Empire BCBS HealthPlus	2019-2021 Not Yet Scheduled											
EverCare	2019-2021 Not Yet Scheduled											
Extended MLTC	2019-2021 Not Yet Scheduled											
Fallon Health	2021-2022 Comprehensive	NC	C	NC	NC	NC	C	C	C	C	NC	C
Fidelis Care	2018-2019 Comprehensive	NC	C	NC	NC	NC	C	C	NC	C	NC	C
Hamaspik	2019-2021 Not Yet Scheduled											
iCircle	2019-2020 Comprehensive	NC	C	NC	NC	NC	C	NC	NC	C	NC	C
Integra	2018-2019 Comprehensive	NC	C	NC	NC	C	C	NC	C	C	NC	C
Kalos Health	2021-2022 Comprehensive	NC	C	NC	NC	NC	C	C	C	C	NC	C
MetroPlus	2019-2021 Not Yet Scheduled											
Montefiore	2019-2021 Not Yet Scheduled											
Nascentia	2020-2021 Comprehensive	NC	C	NC	NC	C	C	C	C	C	C	C
Prime Health	2019-2021 Not Yet Scheduled											
RiverSpring	2020 Comprehensive	C	C	NC	NC	C	C	C	C	C	NC	C
Senior Health Partners	2018-2019 Comprehensive	NC	C	NC	NC	NC	C	NC	NC	C	NC	C
Senior Network Health	2020-2021 Comprehensive	NC	C	NC	NC	NC	C	C	NC	C	C	C
Senior Whole Health	2019-2020 Comprehensive	C	C	NC	NC	NC	C	NC	NC	C	NC	C
VillageCare	2019-2021 Not Yet Scheduled											
VNS Health	2020-2021 Comprehensive	NC	C	NC	C	NC	C	C	NC	C	NC	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 12: Program of All-Inclusive Care for the Elderly Managed Care Plan Compliance Survey Results

Managed Care Plan	Activity	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
ArchCare	2019 No Activity											
	2020 No Activity[1]											
	2021 No Activity[1]											
Catholic Health	2019 No Activity											
	2020 No Activity[1]											
	2021 No Activity[1]											
CenterLight	2019 Comprehensive	C	C	C	C	C	C	C	C	C	C	C
	2020 No Activity[1]											
	2021 No Activity[1]											
Complete Senior Care	2019 No Activity											
	2020 No Activity[1]											
	2021 No Activity[1]											
Eddy SeniorCare	2019 Comprehensive	C	C	C	C	C	C	C	C	C	C	C
	2020 No Activity[1]											
	2021 No Activity[1]											
ElderONE	2019 Comprehensive	C	C	C	C	C	C	C	C	C	C	C
	2020 No Activity[1]											
	2021 No Activity[1]											
Fallon Health	2019 No Activity											
	2020 No Activity[1]											
	2021 No Activity[1]											
PACE CNY	2019 No Activity											
	2020 No Activity[1]											
	2021 No Activity[1]											
Total Senior Care	2019 Comprehensive	C	C	C	C	C	C	C	C	C	C	C
	2020 No Activity[1]											
	2021 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.

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.

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

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
Optional	**External Quality Review Activity 6. Administration of Quality-of-Care Surveys**

Understanding the experiences that New Yorkers have with the Medicaid Managed Long-Term Care program is a priority for the Department of Health. IPRO administers a survey on behalf of the Department of Health every year, alternating between adults and kids. The survey is sent to a group of New Yorkers that received care through one of the Medicaid Managed Long-Term Care plans. IPRO asks these New Yorkers to rate their experiences with the Medicaid Managed Long-Term Care plans, health care services, personal doctors, and specialists. This survey is called the Member Satisfaction Survey.

IPRO ensures that the survey is conducted properly and that the results are calculated correctly.

The Department of Health uses the survey results to monitor Medicaid Managed Long-Term Care plan and provider performance. The Medicaid Managed Long-Term Care plans use the survey results to understand the experience New Yorkers have with the Medicaid program.

In 2021, IPRO surveyed adult New Yorkers who received care in 2020 through a Medicaid Managed Long-Term Care plan.

For more information about the 2021 survey, please read the rest of this section.

Technical Summary – Administration of Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality-of-care may be performed by using information derived during the preceding 12 months. Further, *Title 42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

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

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the quality-of-care survey activity. To meet this federal regulation, the Department of Health contracted with IPRO to administer the *2021 Member Satisfaction Survey* for the Managed Long-Term Care program.

This external quality review report presents the 2021 survey results for the Medicaid Advantage Plus, Program of All-Inclusive Care for the Elderly, and Partial Capitation plans.

Technical Methods of Data Collection and Analysis

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

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

Adults who were current members of a New York State Medicaid managed long-term care plan, and who had been continuously enrolled with the managed care plan for at least six months from March 2020 through August 2020 were eligible to be randomly selected for the survey. A stratified random sample of 600 members was drawn for each managed long-term care plan, resulting in a statewide sample size of 20,558 members. The entire eligible membership was included for Medicaid Managed Long-Term Care plans with an enrollment of less than 600.

Members were surveyed in English, Spanish, Russian, or Chinese. The survey was administered between December 2020 and March 2021 using a mail-only two-wave protocol.

Table 13 provides a summary of the technical methods of data collection.

Table 13: Medicaid Managed Long-Term Care 2021 Member Satisfaction Survey Data Collection Summary

Category	Data Collection Information
Survey Administrator	IPRO
Survey Tool	State-specific
Survey Timeframe	December 2020 to March 2021
Method of Collection	Mail only, two waves
Sample Size	20,558
Number of Completed Surveys	3,659
Response Rate	17.8%

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

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

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

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

Description of Data Obtained

For the external quality review, the IPRO-produced *New York State Department of Health Managed Long-Term Care 2021 Member Satisfaction Survey Report* was referenced. The report included comprehensive descriptions of the project objectives, methodology, and data analysis, as well as results at the statewide and managed long-term care program-levels. The Managed Long-Term Care performance dataset prepared by the Department of Health was also referenced for the external quality review. The dataset included Managed Long-Term Care plan risk-adjusted member satisfaction results, as well as weighted statewide averages.

Comparative Results

Table 14 displays statewide Medicaid Managed Long-Term Care results for the *2021 Member Satisfaction Survey*.

Table 14: Medicaid Managed Long-Term Care Member Satisfaction Results, Measurement Year 2021

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

Medicaid Managed Long-Term Care Plan-Level Reporting

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

- External Quality Review Activity 1. Performance Improvement Projects
- External Quality Review Activity 3. Compliance with Medicaid and Children's Health Insurance Program Standards
- External Quality Review Activity 6. Quality-of-Care Survey, Member Satisfaction

Results from the following activities were not available for inclusion in the 2021 external quality review:

- External Quality Review Activity 2. Performance Measures
- Medicaid Managed Long-Term Care Plan Follow-up on Prior Recommendations

Performance Improvement Project Summary and Results

This section displays the Medicaid Managed Long-Term Care plan's 2021 performance improvement project topic, validation assessment, summary of interventions, and results achieved. The corresponding tables display performance indicators, baseline rates, interim rates, final rates, and targets/goals.

Performance Measures Results

Performance measure results are not available for the period under review. The Department of Health was not able to calculate Medicaid Managed Long-Term Care quality measures, which are based on face-to-face community health assessments, due to COVID-19. A moratorium on community health assessments was put in place by the Department of Health in response to COVID-19.

When data is available, this section displays the Medicaid Managed Long-Term Care plan-level Uniform Assessment System for New York results, as well as program and statewide Medicaid Managed Long-Term Care average performance. A Medicaid 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 Medicaid Managed Long-Term Care plan rate reported below the program average rate is considered an opportunity for improvement.

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

This section displays Medicaid Managed Long-Term Care plan results for the most recent compliance review. A Medicaid 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.

Quality-of-Care Survey Results – Member Experience

This section displays the Managed Long-Term Care plan-level member satisfaction performance for 2021. The corresponding tables display satisfaction measures, risk-adjusted Managed Long-Term Care plan scores, and Managed Long-Term Care program weighted averages. The table also indicates whether the Managed Long-Term Care plan's score was significantly better than the Managed Long-Term Care program's average (indicated by green shading), or whether the Managed Long-Term Care plan's score was significantly worse than the Managed Long-Term Care program's average (indicated by red shading). A Managed Long-Term Care plan scoring significantly better than the Managed Long-Term Care program average for a measure was considered a strength during this evaluation, while a Managed Long-Term Care plan scoring significantly worse than the Managed Long-Term Care program average was considered an opportunity for improvement.

Assessment of Managed Care Plan Follow-up on Prior 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." This report marks the commencement of the Medicaid Managed Long-Term Care plan annual external quality review technical report, and therefore, there were no 2020 external quality review recommendations for the Medicaid Managed Long-Term Care plans to follow-up on.

Strengths, Opportunities for Improvement, and Recommendations

The Medicaid Managed Long-Term Care plan strengths and opportunities for improvement identified during IPRO's external quality review of the activities described are 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.

Medicaid Advantage Plus Managed Care Plan-Level Reporting

AgeWell

Performance Improvement Project Summary and Results

AgeWell did not conduct a performance improvement project for the Medicaid Advantage Plus program for measurement year 2021 due to low enrollment.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

AgeWell's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 15: AgeWell's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although Medicaid Advantage Plan enrollment was low, AgeWell should focus on opportunities where a quality improvement activity, such as a performance improvement project,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	would result in improved quality, timeliness, and/or access to care.			
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.	X	X	X
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
Quality-of-Care Survey	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.	X	X	X

Centers Plan

Performance Improvement Project Summary and Results

Centers Plan did not conduct a performance improvement project for the Medicaid Advantage Plus program for measurement year 2021 due to low enrollment.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Centers Plan's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 16: Centers Plan's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although Medicaid Advantage Plan enrollment was low, Centers Plan should focus on opportunities where a quality improvement activity, such as a performance improvement project,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	would result in improved quality, timeliness, and/or access to care.			
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.	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
Quality-of-Care Survey	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.	X	X	X

Elderplan

Performance Improvement Project Summary and Results

Table 17: Elderplan's Performance Improvement Project Summary, Measurement Year 2021

Elderplan's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Elderplan aimed to reduce emergency room and hospitalization utilization by facilitating regular follow-up between the member and primary care provider, and providing timely access to needed services, as well as access to education on disease and symptom management. Member-Focused 2021 Interventions ▪ Mailed member education on urgent care centers and on the importance of regular primary care provider follow-up and completed follow-up home visits in person to discuss this education when necessary. ▪ Enrolled members into a transitional care program post-discharge, which includes a comprehensive telephonic assessment within two business days of notification of discharge to identify needs, which are communicated to the care management team and primary care provider where applicable. ▪ Educated members during the care planning process and during assessments on the importance of regular follow-up with primary care providers, coordinating visits when necessary. Provider-Focused 2021 Interventions ▪ Sent primary care providers notification letters of member discharge from acute care facility.

Table 18: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Elderplan's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	91.20%	94.80%	96.51%	94.78%	95.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	86.69%	88.40%	91.62%	89.86%	88.00%
Potentially Avoidable Hospitalizations Rate[1]	3.60	0.34	2.38	2.56	3.40

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 19: Elderplan's Member Satisfaction Results, Measurement Year 2021

Measure	Elderplan Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	93%	90%
Rating of Dentist	75%	73%
Rating of Care Manager	93%	88%
Rating of Regular Visiting Nurse	91%	85%
Rating of Home Health Aide	97%	94%
Rating of Transportation Services	71%	78%
Timeliness of Home Health Aide	97%	95%
Timeliness Composite	91%	84%
Involved in Decisions	83%	83%
Manage Illness	87%	86%
Access to Routine Dental Care	50%	35%
Same Day Urgent Dental Care	40%	27%
Plan Asked to See Medicines	99%	93%
Talked About Appointing for Health Decisions	88%	77%
Document Appointing for Health Decisions	78%	63%
Plan Has Document Appointing for Health Decisions	91%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 20: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Elderplan exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Elderplan performed significantly better than the Medicaid Managed Long-Term Care program on nine measures of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Elderplan did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 21: Empire BCBS HealthPlus's Performance Improvement Project Summary, Measurement Year 2021

Empire BCBS HealthPlus's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: The validation findings generally indicate that the credibility of the performance improvement project results was not at risk; however, results must be interpreted with some caution. Empire BCBS HealthPlus reported final measurement year rates, only. The Medicaid Managed Long-Term Care plan did not report baseline or remeasurement data for this performance improvement project.
Aim Empire BCBS HealthPlus aimed to reduce emergency room and hospitalization utilization by enhancing communication initiatives with providers and improving coordination of services. Member-Focused 2021 Interventions ▪ Distributed educational materials to members and caregivers on identifying signs, changes, and symptoms to report to the managed care plan to facilitate early intervention. Provider-Focused 2021 Interventions ▪ Outreached to primary care providers for post-hospitalization management. Managed Care Plan-Focused 2021 Interventions ▪ Educated vendor agencies on best practices and strategies to facilitate communication of changes in member condition with the managed care plan. ▪ Educated care managers on reinforcing communication with members/caregivers/family/stakeholders post-hospitalization to prevent rehospitalization. ▪ Obtained corporate funding to have Lyft® codes available for member use when immediate transportation need is identified. ▪ Utilized reports available in Uniform Assessment System for New York to track and trend member emergency department use and member hospitalizations.

Table 22: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Empire BCBS HealthPlus's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021[1]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	Project Initiated in 2021	Project Initiated in 2021	Project Initiated in 2021	0.00%	95.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days				93.59%	90.50%
Potentially Avoidable Hospitalizations Rate[2]				0.42	1.90

[1] The measurement period for 2021 is July to December of the measurement year.

[2] A lower rate indicates better performance.

Performance Measure Results
Performance measure results are not available for the period under review.

Compliance with Medicaid and Children's Health Insurance Program Standards Results
Compliance review results are not available for the period under review.

Quality-of-Care Survey Results
Empire BCBS HealthPlus's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations
Table 23: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Empire BCBS HealthPlus initiated its performance improvement project in 2021, which was the last year of the state-directed, multi-year project. Given the one-year timeframe for the project, the ability to assess improvement is limited.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	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.			
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.	X	X	X
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Empire BCBS HealthPlus should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Performance Improvement Project Findings

Table 24: Fidelis Care's Performance Improvement Project Summary, Measurement Year 2021

Fidelis Care's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Fidelis Care aimed to reduce emergency room and hospitalization utilization by executing a member education strategy, establishing provider linkages, and promoting coordination of care. Member-Focused 2021 Interventions ▪ Conducted monthly telephonic outreach to all members to identify hospital utilizers, potentially avoidable hospitalizations, and members with missed primary care provider visits within three months. Members with recent emergency room visits were educated on the usage of proper care settings and encouraged to make follow-up primary care provider appointments within seven to ten days of discharge. Members with missing primary care provider visits were encouraged to schedule a primary care provider appointment. ▪ Outreached members who had an emergency room visit, but who did not follow-up with their primary care provider within seven to ten days. ▪ Sent monthly educational packets to members with recent emergency room or hospital utilization. ▪ Conducted post-discharge telephone follow-up calls to reinforce education, address care plan, monitor symptoms and diagnoses, and reconcile medications. ▪ Outreached members, who were included in the daily Healthix report of emergency room and hospitalization utilization, directly or through the home health agency. Provider-Focused 2021 Interventions ▪ Developed better communication processes with providers regarding notification of hospitalizations. ▪ Contacted primary care providers to confirm members' medications and diagnoses. ▪ Primary care providers were encouraged to follow-up with members within seven days of an emergency room visit and/or hospital discharge. Managed Care Plan-Focused 2021 Interventions ▪ Obtained access to regional health information organization data. ▪ Identified members with potentially avoidable hospitalization through monthly telephonic outreach to the entire membership. ▪ Utilized the daily Healthix report to identify members with emergency room visits and/or hospitalizations.

Table 25: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Fidelis Care's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	89.87%	95.95%	88.89%	92.13%	91.40%
Percentage of Members Without a Hospital Stay in the Last 90 Days	88.61%	90.54%	77.78%	88.98%	90.80%
Potentially Avoidable Hospitalizations Rate[1]	8.49	8.30	4.37	5.00	5.00

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Fidelis Care's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 26: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Fidelis Care met or exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Fidelis Care did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Fidelis Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Hamaspik

Performance Improvement Project Summary and Results

Hamaspik did not conduct a performance improvement project for the Medicaid Advantage Plus program for measurement year 2021 due to a mid-year operational start in 2021 and low enrollment.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Hamaspik's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

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

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although Medicaid Advantage Plan enrollment was low, Hamaspik should focus on opportunities where a quality improvement activity, such as a performance improvement project,	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	would result in improved quality, timeliness, and/or access to care.			
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.	X	X	X
Compliance with Federal Managed Care Standards	Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 28: Healthfirst's Performance Improvement Project Summary, Measurement Year 2021

Healthfirst's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Healthfirst aimed to reduce emergency room and hospitalization utilization by implementing information technology-based processes for early identification of members in emergency departments and/or hospitals; facilitating enhanced care coordination services and discharge planning; timely referrals to primary and/or specialty care providers; notifying primary care providers of their patients identified as high utilizers of emergency departments and hospitals; and by providing members with education and resources. Member-Focused 2021 Interventions ▪ Outreached to members and assisted with discharge planning within three business days of post-discharge notification of emergency department visit or hospitalization. ▪ Linked members to primary and/or specialty care and made referrals to community-based services as appropriate within 30 days of discharge notification. Managed Care Plan-Focused 2021 Interventions ▪ Health information exchange encounter reports triggered by emergency department visits and inpatient admissions were used by the case management team to ensure timely discharge planning and outpatient care coordination. ▪ Enhanced internal processes, clinical assessment tools, and automated/integrated reporting to improve the early identification of members with an emergency department or inpatient discharge or who are at risk for a potentially avoidable hospitalization, and to increase timely care coordination.

Table 29: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Healthfirst's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[1]	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021[1]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	90.79%	92.34%	93.88%	92.14%	91.70%
Percentage of Members Without a Hospital Stay in the Last 90 Days	88.66%	89.99%	87.91%	78.61%	89.70%
Potentially Avoidable Hospitalizations Rate[2]	4.56	4.29	4.06	3.30	4.33

[1] The measurement period for 2018, 2019, 2020, and 2021 is July to December of the measurement year.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 30: Healthfirst's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019
438.206: Availability of Services	NC
438.207: Assurances of Adequate Capacity and Services	NC
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: Sub-contractual 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.

Summary of 2019 Results

- Healthfirst failed to provide evidence that enrollees are notified in writing of disenrollment rights and their right to request information annually.
- Healthfirst failed to provide evidence of written notification to members of updates to the provider directory.
- Healthfirst failed to produce evidence of all executed provider contracts in the required sample.
- One of 50 records submitted for review did not contain an Enrollment Agreement; and two records had Enrollment Agreements that were inaccurate or incomplete.
- Eight of 50 records submitted for review lacked timely reassessment during the review period.
- Person-centered service plans on record lacked member specific detail and included inaccurate and/or inappropriate information that did not pertain to the member. In addition, person centered service plans did not consistently indicate scope of services.
- Nine of 50 records submitted for review failed to show evidence of a current person-centered service plan for the full review time period.
- Thirty-four (34) of 50 records submitted for review contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care. In addition, these records contained incomplete contact notes.
- For 14 prior authorization and concurrent reviews following a service request, no evidence was provided that the Healthfirst either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.

Quality-of-Care Survey Results

Table 31: Healthfirst's Member Satisfaction Results, Measurement Year 2021

Measure	Healthfirst Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	88%	90%
Rating of Dentist	74%	73%
Rating of Care Manager	80%	88%
Rating of Regular Visiting Nurse	80%	85%
Rating of Home Health Aide	98%	94%
Rating of Transportation Services	79%	78%
Timeliness of Home Health Aide	93%	95%
Timeliness Composite	78%	84%
Involved in Decisions	87%	83%
Manage Illness	82%	86%
Access to Routine Dental Care	34%	35%
Same Day Urgent Dental Care	31%	27%
Plan Asked to See Medicines	96%	93%
Talked About Appointing for Health Decisions	86%	77%
Document Appointing for Health Decisions	65%	63%
Plan Has Document Appointing for Health Decisions	90%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 32: Healthfirst's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Healthfirst's measurement year 2021 performance improvement project passed validation.	X	X	X
	Healthfirst exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019 review, Healthfirst was in compliance with seven standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	Healthfirst performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Healthfirst did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019 review, Healthfirst was not in full compliance with four standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	Healthfirst performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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, Healthfirst should continue to address member utilization of these services and promote use of appropriate settings of care.	X	X	X
Performance Measures	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. Healthfirst should also consider how to maximize realized positive outcomes of the assessment moratorium.	X	X	X
Compliance with Federal Managed Care Standards	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 compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 33: RiverSpring's Performance Improvement Project Summary, Measurement Year 2021

RiverSpring's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim RiverSpring aimed to improve transitions of care by standardizing the process to request a discharge summary, developing clinical criteria for post-discharge assessments, contacting members within 48 hours post-discharge, and by assisting members with scheduling follow-up. Member-Focused 2021 Interventions ▪ Outreached to member, or representative, within 48 hours of discharge notification to provide instructions and assistance as needed. ▪ Evaluated the clinical criteria of members to determine if a post-discharge Uniform Assessment System for New York Community Health Assessment was needed. ▪ Assisted members in scheduling follow-up appointments within seven days of discharge. Managed Care Plan-Focused 2021 Interventions ▪ Implemented a standardized process for requesting discharge summaries.

Table 34: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

RiverSpring's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	No MAP Enrollment	No MAP Enrollment	75.00%	60.00%	80.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	No MAP Enrollment	No MAP Enrollment	50.00%	Not Available	55.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	No MAP Enrollment	No MAP Enrollment	20.00%	30.00%	18.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results
Performance measure results are not available for the period under review.

Compliance with Medicaid and Children's Health Insurance Program Standards Results
Compliance review results are not available for the period under review.

Quality-of-Care Survey Results
RiverSpring's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations
Table 35: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	RiverSpring did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
Performance Measures	RiverSpring should evaluate the impact of the community health reassessment	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	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.			
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
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, RiverSpring should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

Senior Whole Health

Performance Improvement Project Findings

Table 36: Senior Whole Health's Performance Improvement Project Summary, Measurement Year 2021

Senior Whole Health's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were validation findings that indicate that the credibility was at-risk for the performance improvement project results.
Aim Senior Whole Health aimed to reduce emergency room and hospitalization utilization by identifying members at-risk for an emergency room visit or potentially avoidable hospitalization, implementing interventions to prevent a subsequent admission, and by ensuring members attend follow-up appointments. Member-Focused 2021 Interventions ▪ Educated members on appropriate usage of the emergency department. ▪ Outreached to members who had an emergency room visit in the last 90 days. ▪ Mailed all members a regional health information organization consent form. Provider-Focused 2021 Interventions ▪ Notified primary care providers of patient discharge from the emergency room or hospital. ▪ Distributed value-based payment incentive funds to providers meeting targets. ▪ Conducted bi-annual outreach to the top-10, high-volume providers. Managed Care Plan-Focused 2021 Interventions ▪ Trained case managers and Uniform Assessment System for New York Community Health Assessment assessors. ▪ Distributed case management panel reports weekly and identified members in need of secondary prevention.

Table 37: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Senior Whole Health's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	92.00%	97.22%	95.61%	97.92%	97.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	89.33%	79.17%	81.58%	79.17%	90.00%
Potentially Avoidable Hospitalizations Rate[1]	3.66	3.09	3.34	3.54	2.94

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Senior Whole Health's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 38: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Senior Whole Health exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Senior Whole Health did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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.	X	X	X
Compliance with Federal Managed Care Standards	Senior Whole Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Senior Whole Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

VillageCare

Performance Improvement Project Summary and Results

VillageCare did not conduct a performance improvement project for the Medicaid Advantage Plus program for measurement year 2021 due to low enrollment.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 39: VillageCare's Member Satisfaction Results, Measurement Year 2021

Measure	VillageCare Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	91%	90%
Rating of Dentist	65%	73%
Rating of Care Manager	86%	88%
Rating of Regular Visiting Nurse	77%	85%
Rating of Home Health Aide	94%	94%
Rating of Transportation Services	69%	78%
Timeliness of Home Health Aide	97%	95%
Timeliness Composite	83%	84%
Involved in Decisions	85%	83%
Manage Illness	91%	86%
Access to Routine Dental Care	28%	35%
Same Day Urgent Dental Care	26%	27%
Plan Asked to See Medicines	92%	93%
Talked About Appointing for Health Decisions	73%	77%
Document Appointing for Health Decisions	57%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 40: VillageCare's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	None.			
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although Medicaid Advantage Plan 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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 41: VNS Health's Performance Improvement Project Summary, Measurement Year 2021

VNS Health's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim VNS Health aimed to improve transitions of care by facilitating the sharing of discharge documentation, conducting condition assessments post-discharge, training staff on new processes, and by developing a transition of care script designed to encourage member adherence to treatment plans. Member-Focused 2021 Interventions ▪ Educated members within 30 days of discharge on the importance of follow-up after hospitalization using an updated transition of care script. ▪ Assisted members with scheduling aftercare appointments. ▪ Referred members needing medication reconciliation to their primary care provider for completion within 30 days of discharge. Managed Care Plan-Focused 2021 Interventions ▪ Conducted quarterly care management audits to assess transition of care workflows, specifically hospital outreach discharge summary requests, and assistance in arranging follow-up care. ▪ Implemented a process to track member attendance at post-discharge aftercare appointments.

Table 42: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

VNS Health's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	Not Available	9.32%	19.25%	25.74%	21.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	Not Available	4.45%	12.12%	Not Available	20.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	Not Available	28.71%	21.70%	12.38%	19.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 43: VNS Health's Member Satisfaction Results, Measurement Year 2021

Measure	VNS Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	95%	90%
Rating of Dentist	69%	73%
Rating of Care Manager	85%	88%
Rating of Regular Visiting Nurse	83%	85%
Rating of Home Health Aide	93%	94%
Rating of Transportation Services	71%	78%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	81%	84%
Involved in Decisions	70%	83%
Manage Illness	90%	86%
Access to Routine Dental Care	29%	35%
Same Day Urgent Dental Care	39%	27%
Plan Asked to See Medicines	94%	93%
Talked About Appointing for Health Decisions	77%	77%
Document Appointing for Health Decisions	66%	63%
Plan Has Document Appointing for Health Decisions	86%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 44: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	VNS Health exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	VNS Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	VNS Health performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	VNS Health should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Partial Capitation Managed Care Plan-Level Reporting

Performance Improvement Project Findings

Table 45: Aetna's Performance Improvement Project Summary, Measurement Year 2021

Aetna's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Aetna aimed to reduce emergency room and hospitalization utilization by implementing effective communication processes across care coordination and establishing relationships with regional health information organizations. Member-Focused 2021 Interventions ▪ Educated members on self-management of chronic conditions and appropriate use of emergency room services. Provider-Focused 2021 Interventions ▪ Educated paraprofessionals on identifying early warning signs and symptoms of chronic condition changes, and appropriate use of emergency room services. Managed Care Plan-Focused 2021 Interventions ▪ Developed a comprehensive clinical monthly assessment tool for care managers to use during telephonic outreach to members with recent emergency room visits. ▪ Explored regional health information organization memberships for access to data that could be used to address potentially avoidable hospitalizations.

Table 46: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Aetna's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[1]	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021[1]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	95.29%	96.08%	94.11%	95.61%	99.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	91.19%	92.61%	76.82%	89.58%	95.00%
Potentially Avoidable Hospitalizations Rate[2]	3.20	3.29	2.93	Not Available	2.8

[1] The measurement period for 2018, 2019, 2020, and 2021 is July to December of the measurement year.
[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 47: Aetna's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
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: Sub-contractual 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.

Summary of 2020-2021 Results

- Aetna failed to provide evidence that credentialing and re-credentialing are performed for participating providers. *(Contract Article VII Section C.2 (a))*
- Aetna failed to provide evidence that monitoring of providers is performed for fiscal intermediaries. *(Contract Article VII Section C. 1)*
- 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. *(Contract Article V C. 1, H. 5)*
- 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. *(Contract Article V J. 1)*
- 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 decision was sent within the required timeframe. *(Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements)*
- 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. *(Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements)*
- 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. *(Contract Article V D.1.a, D.1.e)*
- Aetna failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*. *(Contract Article VII Section C.2 (a))*
- Aetna failed to provide evidence of required annual vendor site visits. *(Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20, Contract Article VII Section C.2 (a))*
- Aetna failed to provide evidence of an executed contract that includes social day care requirements. *(Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20, Contract Article VII Section C.2 (a))*

- Documentation provided by Aetna identified failure to routinely comply with the Conflict Free Evaluation and Enrollment Center dispute resolution process to resolve eligibility discrepancies. *(Contract Appendix P.II)*

Quality-of-Care Survey Results

Table 48: Aetna's Member Satisfaction Results, Measurement Year 2021

Measure	Aetna's Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	97%	90%
Rating of Dentist	81%	73%
Rating of Care Manager	93%	88%
Rating of Regular Visiting Nurse	84%	85%
Rating of Home Health Aide	97%	94%
Rating of Transportation Services	88%	78%
Timeliness of Home Health Aide	97%	95%
Timeliness Composite	90%	84%
Involved in Decisions	84%	83%
Manage Illness	84%	86%
Access to Routine Dental Care	33%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%
Plan Asked to See Medicines	94%	93%
Talked About Appointing for Health Decisions	65%	77%
Document Appointing for Health Decisions	62%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.
Sample size too small to report means that the denominator is less than 30 members.
Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 49: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Aetna was in compliance with seven standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Aetna performed significantly better than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Aetna did not meet the target rate for two performance indicators.	X	X	X
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 Subpart D.*	X	X	X
Quality-of-Care Survey	Aetna performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	Aetna should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2020-2021 compliance findings. Aetna should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Aetna 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.	X	X	X

Performance Improvement Project Findings

Table 50: AgeWell's Performance Improvement Project Summary, Measurement Year 2021

AgeWell's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim AgeWell aimed to improve transitions of care by identifying gaps in its current transitions of care process, and by implementing interventions that support the provision of team-based, coordinated care post-discharge. Member-Focused 2021 Interventions ▪ Educated members on the importance of timely notification of hospital admission to the managed care plan. ▪ Obtained member consent to share information with Healthix, a regional health information organization, so that the managed care plan could receive notifications. ▪ Assisted members in scheduling follow-up appointments with their primary care providers. Provider-Focused 2021 Interventions ▪ Outreached to licensed home care services agencies and fiscal intermediaries to obtain hospital notifications. Managed Care Plan-Focused 2021 Interventions ▪ Assigned a team of nurse assessors to complete post-hospitalization assessments.

Table 51: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

AgeWell's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	40.62%	54.07%	62.56%	55.29%	55.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	33.88%	56.58%	16.13%	Not Available	60.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	16.57%	13.80%	13.95%	7.19%	14.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 52: AgeWell's Member Satisfaction Results, Measurement Year 2021

Measure	AgeWell Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	95%	90%
Rating of Dentist	81%	73%
Rating of Care Manager	95%	88%
Rating of Regular Visiting Nurse	94%	85%
Rating of Home Health Aide	100%	94%
Rating of Transportation Services	85%	78%
Timeliness of Home Health Aide	99%	95%
Timeliness Composite	91%	84%
Involved in Decisions	87%	83%
Manage Illness	88%	86%
Access to Routine Dental Care	38%	35%
Same Day Urgent Dental Care	36%	27%
Plan Asked to See Medicines	96%	93%
Talked About Appointing for Health Decisions	67%	77%
Document Appointing for Health Decisions	56%	63%
Plan Has Document Appointing for Health Decisions	87%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 53: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	AgeWell exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	AgeWell performed significantly better than the Medicaid Managed Long-Term Care program on eight measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	AgeWell performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
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
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 54: ArchCare's Performance Improvement Project Summary, Measurement Year 2021

ArchCare's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim ArchCare aimed to reduce emergency room and hospitalization utilization by improving member self-management of chronic diseases. Member-Focused 2021 Interventions ▪ Educated members quarterly on disease management and potentially avoidable hospitalizations. ▪ Assessment nurses presented members with a regional health information organization consent form during assessment visits. Provider-Focused 2021 Interventions ▪ For each regional health information organization alert received, the managed care plan notified the primary care provider and assisted the member in scheduling a primary care follow-up visit to occur within 2 weeks of return to community. Managed Care Plan-Focused 2021 Interventions ▪ Potentially avoidable hospitalization and disease management education was incorporated into the managed care plan's orientation and made available through the e-learning system. ▪ Case managers captured emergency room and hospitalization admissions in the care management system for each regional health information organization alert received.

Table 55: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

ArchCare's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	91.79%	92.02%	94.31%	93.47%	95.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	84.70%	87.73%	86.35%	86.65%	90.00%
Potentially Avoidable Hospitalizations Rate[1]	4.38	5.87	7.60	3.86	2.94

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 56: ArchCare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D and Quality Assurance and Performance Improvement Program Standards	2019-2020
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: Sub-contractual 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.

Summary of 2019-2020 Results

- ArchCare failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- ArchCare failed to provide evidence of required annual vendor site visits.
- ArchCare failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- ArchCare failed to complete background checks on all personnel.
- ArchCare failed to accurately maintain the Uniform Assessment System for New York Community Health Assessment case list.
- Documentation provided by ArchCare indicates that dual eligible enrollees were erroneously denied enrollment.
- Documentation provided by ArchCare identified failure to routinely comply with the Conflict-Free Evaluation and Enrollment Center dispute resolution process to resolve eligibility discrepancies.
- Five records contained 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.
- Three records lacked timely reassessment during the review period.
- 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.
- Twenty-one (21) records did not include evidence that enrollees were provided with written notification of the person-centered service plan.
- Twenty-seven (27) records did not contain a back-up plan; ArchCare incorrectly documented those members were not required to have a back-up support agreement.
- Of the 13 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, 11 records did not contain current physician orders.
- Of the 13 records indicating the enrollee was receiving Consumer Directed Personal Assistance Services, five showed evidence that the consumer directed personal assistant was the designated representative or was acting as the designated representative.

- Thirty (30) records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care. In addition, the care management notes did not consistently reflect updated changes to the member's status each month.
- Twenty-nine (29) records lacked evidence of monthly contact with the member.
- Eleven (11) records lacked documented evidence of a care management home visit.
- For six complaints that could not be resolved immediately, no evidence was provided that the enrollee was sent acknowledgment and/or resolution notices.
- Extension notices lacked specific information needed by ArchCare to make a determination; they failed to give an appropriate reason for the delay and how the delay is in the best interest of the enrollee.
- 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.
- 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.
- Ten decisions pertaining to a reduction did not identify the change in medical condition, mental condition, or social circumstance that supports the reduction, and the rationales lack member-specific detail.
- For 28 appeals of decisions, no evidence was provided that ArchCare sent the determination within the required timeframe; ArchCare did not consistently manage appeals of concurrent reviews as expedited.
- Four records submitted for review contained an intent to involuntary disenroll notice that was not the Department of Health-approved template.
- For three records that contained a disenrollment, ArchCare failed to initiate an involuntary disenrollment within the required timeframe.

Quality-of-Care Survey Results

Table 57: ArchCare's Member Satisfaction Results, Measurement Year 2021

Measure	ArchCare Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	84%	90%
Rating of Dentist	72%	73%
Rating of Care Manager	88%	88%
Rating of Regular Visiting Nurse	80%	85%
Rating of Home Health Aide	97%	94%
Rating of Transportation Services	78%	78%
Timeliness of Home Health Aide	94%	95%
Timeliness Composite	82%	84%
Involved in Decisions	70%	83%
Manage Illness	87%	86%
Access to Routine Dental Care	44%	35%
Same Day Urgent Dental Care	23%	27%
Plan Asked to See Medicines	94%	93%
Talked About Appointing for Health Decisions	76%	77%
Document Appointing for Health Decisions	81%	63%
Plan Has Document Appointing for Health Decisions	91%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.
Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 58: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019-2020 review, ArchCare was in compliance with five standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	ArchCare performed significantly better than the Medicaid Managed Long-Term	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Care program on one measure of member satisfaction.			
Opportunities for Improvement				
Performance Improvement Project	ArchCare did not meet the target rate for any performance indicator.	X	X	X
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 Subpart D.*	X	X	X
Quality-of-Care Survey	ArchCare performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	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.	X	X	X

Centers Plan

Performance Improvement Project Findings

Table 59: Centers Plan's Performance Improvement Project Summary, Measurement Year 2021

Centers Plan's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Centers Plan aimed to improve transitions of care by providing members with comprehensive care management including medication reconciliation, scheduling appropriate follow-up care, and disease management education. Member-Focused 2021 Interventions ▪ Assisted members in scheduling follow-up appointments with their primary care provider or a specialist. ▪ Coordinated transportation as needed. ▪ Provided education on the importance of adherence to the care plan, including confirmation of follow-up visit post-discharge. ▪ Provided education on disease management, including the red-yellow-green zone tool for members discharged from an inpatient facility with a diagnosis from the potentially avoidable hospitalization list of conditions. ▪ Conducted medication reconciliation with the member within ten days post-discharge.

Table 60: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Centers Plan's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	57.31%	67.02%	79.85%	67.60%	≥ 65.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	92.30%	86.90%	10.34%	Not Available	≥ 96.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	17.26%	19.22%	21.89%	19.80%	≤ 10.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 61: Centers Plan's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021
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: Sub-contractual 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.

Summary of 2021 Results

- Centers Plan failed to provide evidence of appropriate credentialing to confirm qualifications and complete background checks for all personnel. *(Contract Article V Section J. 2, 5(g))*
- Centers Plan failed to provide evidence that credentialing and re-credentialing are performed on participating providers. *(Contract Article VII Section C. 1)*
- Two records submitted for review did not include a completed enrollment agreement. *(Article V H.5)*
- One record did not contain an acknowledgement or determination notice to enrollee for a grievance that could not be resolved immediately. *(Contract Appendix K.A)*
- Centers Plan failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*. *(Contract Article VII Section C.2 (a)(i)(ii)(iii))*
- Centers Plan failed to provide evidence of required vendor site visits. *(Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20, Contract Article VII Section C.2 (a)(i)(ii)(iii))*
- Three records that indicated the enrollee is receiving Consumer Directed Personal Assistance Services showed that the consumer directed personal assistant is the designated representative or is acting as the designated representative. *(Contract Article V K. 3)*

Quality-of-Care Survey Results

Table 62: Centers Plan's Member Satisfaction Results, Measurement Year 2021

Measure	Centers Plan Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	94%	90%
Rating of Dentist	71%	73%
Rating of Care Manager	94%	88%
Rating of Regular Visiting Nurse	91%	85%
Rating of Home Health Aide	99%	94%
Rating of Transportation Services	61%	78%
Timeliness of Home Health Aide	96%	95%
Timeliness Composite	83%	84%
Involved in Decisions	82%	83%
Manage Illness	83%	86%
Access to Routine Dental Care	24%	35%
Same Day Urgent Dental Care	19%	27%
Plan Asked to See Medicines	90%	93%
Talked About Appointing for Health Decisions	79%	77%
Document Appointing for Health Decisions	63%	63%
Plan Has Document Appointing for Health Decisions	79%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 63: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Centers Plan exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021 review, Centers Plan was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	Centers Plan performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Centers Plan did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021 review, Centers Plan was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	Centers Plan performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	Centers Plan should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Elderplan

Performance Improvement Project Findings

Table 64: Elderplan's Performance Improvement Project Summary, Measurement Year 2021

Elderplan's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Elderplan aimed to reduce emergency room and hospitalization utilization by facilitating regular follow-up between the member and primary care provider, and providing timely access to needed services, as well as access to education on disease and symptom management. Member-Focused 2021 Interventions ▪ Mailed member education on urgent care centers and on the importance of regular primary care provider follow-up and completed follow-up home visits in person to discuss this education when necessary. ▪ Enrolled members into a transitional care program post-discharge, which includes a comprehensive telephonic assessment within two business days of notification of discharge to identify needs, which are communicated to the care management team and primary care provider where applicable. ▪ Educated members during the care planning process and during assessments on the importance of regular follow-up with primary care providers, coordinating visits when necessary. Provider-Focused 2021 Interventions ▪ Sent primary care providers notification letters of member discharge from acute care facility.

Table 65: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Elderplan's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	94.20%	95.40%	93.20%	94.14%	95.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	88.40%	90.20%	90.13%	86.32%	90.00%
Potentially Avoidable Hospitalizations Rate[1]	Not Available	Not Available	Not Available	Not Available	0.16

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 66: Elderplan's Member Satisfaction Results, Measurement Year 2021

Measure	Elderplan Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	94%	90%
Rating of Dentist	78%	73%
Rating of Care Manager	93%	88%
Rating of Regular Visiting Nurse	91%	85%
Rating of Home Health Aide	94%	94%
Rating of Transportation Services	79%	78%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	86%	84%
Involved in Decisions	86%	83%
Manage Illness	86%	86%
Access to Routine Dental Care	38%	35%
Same Day Urgent Dental Care	30%	27%
Plan Asked to See Medicines	94%	93%
Talked About Appointing for Health Decisions	78%	77%
Document Appointing for Health Decisions	55%	63%
Plan Has Document Appointing for Health Decisions	79%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 67: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Elderplan performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Elderplan did not meet the target rate for two performance indicators.	X	X	X
	Elderplan did not report a rate for the *Potentially Avoidable Hospitalizations* indicator for any measurement period.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	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.	X	X	X

Elderwood

Performance Improvement Project Findings

Table 68: Elderwood's Performance Improvement Project Summary, Measurement Year 2021

Elderwood's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Elderwood aimed to reduce emergency room and hospitalization utilization by promoting health literacy on the proper use of the emergency department, and by educating members on prevention strategies for potentially avoidable hospitalizations in collaboration with the member's primary care providers. Member-Focused 2021 Interventions ▪ Continued outreach to members for better compliance, including verbal education and education materials mailed to members. Provider-Focused 2021 Interventions ▪ Established evidence-based prevention strategy documentation for each potentially avoidable hospitalization through research and discussion with the primary care provider and medical director. ▪ Collaborated with physicians on member outreach for better compliance, including verbal education and education materials mailed to members. Managed Care Plan-Focused 2021 Interventions ▪ Aligned with the Rochester Regional Health Information Organization to receive data related to admissions, discharges, and transfers for members residing in Monroe County in New York.

Table 69: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Elderwood's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[1]	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021[2]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	87.19%	78.00%[3]	87.21%	77.54%	94.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	87.54%	Not Available	84.57%	80.51%	91.00%
Potentially Avoidable Hospitalizations Rate[4]	4.52[3]	3.13[3]	4.57[3]	Not Available	2.76

[1] The measurement period for 2018, 2019, and 2020 is January to June of the measurement year.

[2] The measurement period for the 2021 rate reported for *Percentage of Members Without an Emergency Room Visit in the Last 90 Days* and *Percentage of Members Without a Hospital Stay in the Last 90 Days* is July to December of the measurement year.

[3] Rate was calculated by the Department of Health.

[4] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 70: Elderwood's Member Satisfaction Results, Measurement Year 2021

Measure	Elderwood Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	99%	90%
Rating of Dentist	81%	73%
Rating of Care Manager	93%	88%
Rating of Regular Visiting Nurse	91%	85%
Rating of Home Health Aide	93%	94%
Rating of Transportation Services	79%	78%
Timeliness of Home Health Aide	99%	95%
Timeliness Composite	88%	84%
Involved in Decisions	91%	83%
Manage Illness	88%	86%
Access to Routine Dental Care	51%	35%
Same Day Urgent Dental Care	23%	27%
Plan Asked to See Medicines	95%	93%
Talked About Appointing for Health Decisions	72%	77%
Document Appointing for Health Decisions	73%	63%
Plan Has Document Appointing for Health Decisions	85%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 71: Elderwood's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Elderwood measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Elderwood performed significantly better than the Medicaid Managed	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Long-Term Care program on six measures of member satisfaction.			
Opportunities for Improvement				
Performance Improvement Project	Elderwood did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 72: Empire BCBS HealthPlus's Performance Improvement Project Summary, Measurement Year 2021

Empire BCBS HealthPlus's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Empire BCBS HealthPlus aimed to reduce emergency room and hospitalization utilization by enhancing communication initiatives with providers and improving coordination of services. Member-Focused 2021 Interventions ▪ Distributed educational materials to members and caregivers on identifying signs, changes, and symptoms to report to the managed care plan to facilitate early intervention. Provider-Focused 2021 Interventions ▪ Care managers outreached to primary care providers for post-hospitalization management. Managed Care Plan-Focused 2021 Interventions ▪ Educated vendor agencies on best practices and strategies to facilitate communication of changes in member condition with the managed care plan. ▪ Educated care managers on reinforcing communication with members/caregivers/family/stakeholders post-hospitalization to prevent rehospitalization. ▪ Obtained corporate funding to have Lyft® codes available for member use when immediate transportation need is identified. ▪ Utilized reports available in Uniform Assessment System for New York to track and trend member emergency department use and member hospitalizations.

Table 73: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Empire BCBS HealthPlus's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[1]	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021[1]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	93.87%	94.51%	96.14%	95.58%	95.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	89.85%	90.79%	92.33%	91.88%	90.50%
Potentially Avoidable Hospitalizations Rate[2]	4.55	3.60	1.59	2.24	1.90

[1] The measurement period for 2018, 2019, 2020, and 2021 is July to December of the measurement year.
[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 74: Empire BCBS HealthPlus's Member Satisfaction Results, Measurement Year 2021

Measure	Empire BCBS HealthPlus Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	88%	90%
Rating of Dentist	66%	73%
Rating of Care Manager	92%	88%
Rating of Regular Visiting Nurse	85%	85%
Rating of Home Health Aide	93%	94%
Rating of Transportation Services	81%	78%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	80%	84%
Involved in Decisions	83%	83%
Manage Illness	87%	86%
Access to Routine Dental Care	46%	35%
Same Day Urgent Dental Care	33%	27%
Plan Asked to See Medicines	93%	93%
Talked About Appointing for Health Decisions	78%	77%
Document Appointing for Health Decisions	66%	63%
Plan Has Document Appointing for Health Decisions	82%	83%

Strengths, Opportunities for Improvement, and Recommendations

Table 75: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Empire BCBS HealthPlus exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Empire BCBS HealthPlus did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 76: EverCare's Performance Improvement Project Summary, Measurement Year 2021

EverCare's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim EverCare aimed to improve transitions of care by increasing member participation in regional health information organizations; conducting timely Uniform Assessment System for New York Community Health Assessments post-discharge; and by implementing a telephone option for post-discharge assessments. Member-Focused 2021 Interventions ▪ Promoted member sign-off on regional health information organization consent forms for HealtheConnections. Provider-Focused 2021 Interventions ▪ Called hospitals, physician practices and skilled nursing facilities to obtain member discharge summaries. Managed Care Plan-Focused 2021 Interventions ▪ Tracked the timeliness of Uniform Assessment System for New York Community Health Assessments post-discharge.

Table 77: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

EverCare's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	50.66%	85.08%	63.62%	84.88%	75.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	Not Available	53.04%	Not Available	Not Available	85.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	13.77%	11.60%	18.42%	23.68%	8.40%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 78: EverCare's Member Satisfaction Results, Measurement Year 2021

Measure	EverCare Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	91%	90%
Rating of Dentist	67%	73%
Rating of Care Manager	89%	88%
Rating of Regular Visiting Nurse	79%	85%
Rating of Home Health Aide	95%	94%
Rating of Transportation Services	83%	78%
Timeliness of Home Health Aide	97%	95%
Timeliness Composite	85%	84%
Involved in Decisions	91%	83%
Manage Illness	85%	86%
Access to Routine Dental Care	45%	35%
Same Day Urgent Dental Care	23%	27%
Plan Asked to See Medicines	95%	93%
Talked About Appointing for Health Decisions	78%	77%
Document Appointing for Health Decisions	89%	63%
Plan Has Document Appointing for Health Decisions	92%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 79: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	EverCare exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	EverCare performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	EverCare did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Extended MLTC

Performance Improvement Project Findings

Table 80: Extended MLTC's Performance Improvement Project Summary, Measurement Year 2021

Extended MLTC's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Extended MLTC aimed to improve transitions of care by encouraging members to obtain timely and appropriate follow-up care post-discharge; promoting chronic-disease self-management; and by supporting communication and collaboration between providers and health plan staff. Member-Focused 2021 Interventions ▪ Obtained member consent for regional health information organization access. ▪ Care managers educated members on the importance of receiving a post-discharge reassessment during the post-discharge telephonic care manager contact. ▪ Contacted members weekly for a month following an inpatient discharge to assess compliance with discharge instructions and to identify additional needs. Managed Care Plan-Focused 2021 Interventions ▪ Implemented real-time notifications of inpatient admissions and discharges to the managed care plan from the regional health information organization. ▪ Identified on-call care management staff to contact inpatient facilities within 1 day of admission notification. ▪ Assigned the transitional department the role of contacting inpatient facilities at least three times a week to coordinate discharge planning, as well as contacting them within 1 day of discharge notification to confirm discharge and to request discharge summary documentation. ▪ Revised the inpatient discharge care management protocol to include post-discharge telephonic care management contact.

Table 81: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Extended MLTC's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	65.60%	79.75%	83.83%	81.50%	85.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	65.55%	67.52%	82.02%	Not Available	80.00%

Extended MLTC's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	25.20%	14.25%	21.84%	24.25%	20.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.
[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 82: Extended MLTC's Member Satisfaction Results, Measurement Year 2021

Measure	Extended MLTC Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	85%	90%
Rating of Dentist	79%	73%
Rating of Care Manager	93%	88%
Rating of Regular Visiting Nurse	93%	85%
Rating of Home Health Aide	93%	94%
Rating of Transportation Services	80%	78%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	90%	84%
Involved in Decisions	75%	83%
Manage Illness	83%	86%
Access to Routine Dental Care	30%	35%
Same Day Urgent Dental Care	21%	27%
Plan Asked to See Medicines	88%	93%
Talked About Appointing for Health Decisions	55%	77%
Document Appointing for Health Decisions	52%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 83: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Extended MLTC performed significantly better than the Medicaid Managed Long-	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Term Care program on two measures of member satisfaction.			
Opportunities for Improvement				
Performance Improvement Project	Extended MLTC did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Extended MLTC performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
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
Quality-of-Care Survey	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.	X	X	X

Fallon Health

Performance Improvement Project Findings

Table 84: Fallon Health's Performance Improvement Project Summary, Measurement Year 2021

Fallon Health's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Fallon Health aimed to reduce emergency room and hospitalization utilization by educating members on proper utilization these settings of care and supporting member linkages to primary care. Member-Focused 2021 Interventions ▪ Linked all new members that had a potentially avoidable hospitalization diagnosis with an established primary care provider or clinic. ▪ Ensured members had access to timely care, which was determined by asking the members. ▪ Linked members to new primary care provider or clinic based on an answer of "no" on the timeliness of care question in the telephonic member survey. ▪ Educated members on appropriate utilization of services and available resources for care. Provider-Focused 2021 Interventions ▪ Outreached to primary care providers when high utilization of the emergency room was observed.

Table 85: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Fallon Health's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	84.69%	86.54%	87.13%	87.35%	91.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	97.84%	86.95%	92.41%	93.29%	89.00%
Potentially Avoidable Hospitalizations Rate[1]	2.65	4.71	4.36	4.08	1.00

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 86: Fallon Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022
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: Sub-contractual 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.

Summary of 2021-2022 Results

- 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. *(Contract Article V Section F.1(a))*
- Fallon Health did not provide sufficient evidence that the quality committee met four times in 2020 and 2021. *(Contract Article V Section F.1(a))*
- Fallon Health failed to provide evidence that credentialing and re-credentialing are performed on participating providers on a periodic basis (initially and not less than once every three years) and for monitoring provider performance. *(Contract Article VII Section C. 1)*
- Fallon Health failed to provide evidence of appropriate credentialing to confirm qualifications and complete background checks for all personnel. *(Contract Article V Section J. 2, 5(g))*
- Fallon Health failed to provide evidence that monitoring of providers is performed for fiscal intermediaries. *(Contract Article V11 Section A.1, Section C. 1)*
- 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. *(Contract Article V D.4.f, Policy 13.14: Questions regarding Managed Long Term Care Eligibility)*
- One record submitted for review contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment. *(Contract Article V C.1, Article V H.5)*
- 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. *(Contract Article V J.1, J.9.c.vii)*
- Seven records submitted for review did not contain a written back-up plan or the back-up plan was incomplete. *(Contract Article V J.9.c.vi)*
- Twenty-one (21) records submitted for review contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care *(Contract Article V J.1).*
- 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 New York State Official Compilation of Codes, Rules, and Regulations Section 505.28 (d)(1)(i-iv), (f)(1), (e)(4)).*

- 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. *(Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements)*
- Fallon Health failed to provide evidence that, once in each quarter, the governing authority shall assemble and for each such assembly provide prior notice to and shall include in each such assembly each enrollee or consumer representative and/or enrollee advisory council member elected or appointed to represent Fallon Health's enrollees. *(Title 10 New York State Official Compilation of Codes, Rules, and Regulations Part 98 1.6 (a))*.
- Fallon Health failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*. *(Contract Article VII Section C.2 (a))*
- Fallon Health failed to provide evidence of required annual vendor site visits. *(Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20, Contract Article VII Section C.2 (a))*
- Thirty-four (34) records submitted for review lacked evidence of monthly contact with the enrollee. *(Contract Article V J.6.a.)*
- Two records that indicated the enrollee was receiving Consumer Directed Personal Assistance Services did not show evidence of a signed *Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative*. *(Contract Policy for the Transition of Consumer Directed Personal Assistance Services into Managed Care)*
- Six records submitted for review that indicated the enrollee was receiving Consumer Directed Personal Assistance Services showed evidence that the consumer directed personal assistant is the designated representative or is acting as the designated representative. *(Title 18 New York State Official Compilation of Codes, Rules, and Regulations Section 505.28(b) (3)(5), Contract Article V K.3)*

Quality-of-Care Survey Results

Table 87: Fallon Health's Member Satisfaction Results, Measurement Year 2021

Measure	Fallon Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	89%	90%
Rating of Dentist	75%	73%
Rating of Care Manager	90%	88%
Rating of Regular Visiting Nurse	86%	85%
Rating of Home Health Aide	89%	94%
Rating of Transportation Services	81%	78%
Timeliness of Home Health Aide	93%	95%
Timeliness Composite	78%	84%
Involved in Decisions	86%	83%
Manage Illness	82%	86%
Access to Routine Dental Care	46%	35%
Same Day Urgent Dental Care	15%	27%
Plan Asked to See Medicines	92%	93%
Talked About Appointing for Health Decisions	65%	77%
Document Appointing for Health Decisions	60%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 88: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021-2022 review, Fallon Health was in compliance with six standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Fallon Health did not meet the target rate for two performance indicators.	X	X	X
	Fallon Health selected a target rate of improvement for the *Percentage of Members Without a Hospital Stay in the Last 90 Days* indicator that was lower than Fallon Health's baseline rate.	X	X	X
Performance Measures	None.			
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 Subpart D.*	X	X	X
Quality-of-Care Survey	Fallon Health performed significantly worse than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
	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.	X	X	X
Performance Measures	Fallon Health should evaluate the impact of the community health reassessment	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	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.			
Compliance with Federal Managed Care Standards	Fallon Health should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 89: Fidelis Care's Performance Improvement Project Summary, Measurement Year 2021

Fidelis Care's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Fidelis Care aimed to reduce emergency room and hospitalization utilization by executing a member education strategy, establishing provider linkages, and promoting coordination of care. Member-Focused 2021 Interventions ▪ Conducted monthly telephonic outreach to all members to identify hospital utilizers, potentially avoidable hospitalizations, and members with missed primary care provider visits within three months. Members with recent emergency room visits were educated on the usage of proper care settings and encouraged to make follow-up primary care provider appointments within seven to ten days of discharge. Members with missing primary care provider visits were encouraged to schedule a primary care provider appointment. ▪ Outreached members who had an emergency room visit, but who did not follow-up with their primary care provider within seven to ten days. ▪ Sent monthly educational packets to members with recent emergency room or hospital utilization. ▪ Conducted post-discharge telephone follow-up calls to reinforce education, address care plan, monitor symptoms and diagnoses, and reconcile medications. ▪ Outreached members, who were included in the daily Healthix report of emergency room and hospitalization utilization, directly or through the home health agency. Provider-Focused 2021 Interventions ▪ Developed better communication processes with providers regarding notification of hospitalizations. ▪ Contacted primary care providers to confirm members' medications and diagnoses. ▪ Primary care providers were encouraged to follow-up with members within seven days of an emergency room visit and/or hospital discharge. Managed Care Plan-Focused 2021 Interventions ▪ Obtained access to regional health information organization data. ▪ Identified members with potentially avoidable hospitalization through monthly telephonic outreach to the entire membership. ▪ Utilized the daily Healthix report to identify members with emergency room visits and/or hospitalizations.

Table 90: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Fidelis Care's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	92.42%	92.83%	92.47%	91.06%	92.80%
Percentage of Members Without a Hospital Stay in the Last 90 Days	86.02%	88.87%	80.21%	81.14%	87.10%
Potentially Avoidable Hospitalizations Rate[1]	8.33	6.95	4.32	3.31	5.00

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 91: Fidelis Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2018-2019
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: Sub-contractual 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.

Summary of 2018-2019 Results

- Fidelis Care failed to provide evidence that a member advisory committee had been established, meets regularly and reports to the board of directors.
- Fidelis Care did not provide evidence of board-level accountability for overall oversight of program activities and review of the quality assurances and performance improvement program.
- Fidelis Care failed to produce evidence of vendor oversight for social day care providers to assure compliance with *9 New York Codes, Rules and Regulations 6654.20*.
- Fidelis Care failed to provide executed contracts between the managed care plan and the social day care provider that included required provisions.
- Fidelis Care failed to provide evidence of required annual vendor site visits.

- Fidelis Care failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- Fidelis Care failed to provide evidence that enrollees were notified in writing of disenrollment rights and their right to request information annually.
- Fidelis Care failed to provide evidence of annual written notification to members of updates to the provider directory.
- Eleven (11) records submitted for review contained 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. In addition, two records did not contain an enrollment agreement and one was not signed by the enrollee.
- Eight individuals who were identified as eligible for managed long-term care by the Conflict-Free Evaluation and Enrollment Center were assessed by the managed care plan and found not eligible for enrollment. The managed care plan failed to provide evidence that the dispute resolution process was followed.
- Twenty-three (23) of 56 records lacked timely reassessments during the review period.
- Thirty-eight (38) of 56 records did not include evidence that enrollees were provided with written notification of the current person-centered service plan.
- Thirteen (13) of 56 records did not contain current finalized person-centered service plans that were updated within the previous six months.
- Twenty-four (24) of 56 records with current plans of care on record contain inaccurate or incomplete information. The plans of care did not consistently indicate the scope of services or include all authorized services.
- Thirty-three (33) of 56 records did not contain a back-up plan or the back-up plan is incomplete.
- Forty (40) of 56 records contained documentation within the care management notes that was not member specific and/or information that is inconsistent or inaccurate when compared to other care management notes or other documentation contained in the record including but not limited to the plan of care, the community health assessment, and/or notices to the member.
- Twenty-eight (28) of 56 records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care.
- Thirteen (13) of 56 records lacked evidence of monthly contact with the member.
- Of the 31 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, none of the records contained a complete and/or updated physician's order.
- Of the 31 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, four records showed evidence that the consumer directed personal assistant is the designated representative or is acting as the designated representative.
- Of the 31 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, eight records did not show evidence of a signed Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative Form.
- Thirty-eight (38) of 52 prior authorization and concurrent reviews following a service request did not show evidence that the managed care plan notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.
- Seven of eight decisions pertaining to a reduction did not identify a change in medical condition, mental condition or social circumstance that supports the reduction.
- Documentation from the managed care plan indicated that two enrollees who were identified as having a spend-down were not billed each month of the record review period.
- Of the eight records that indicate the enrollee was involuntary disenrolled, all eight records indicated that the managed care plan failed to provide written notice of the intent to disenroll prior to the proposed disenrollment date as part of the enrollee record.

Quality-of-Care Survey Results

Table 92: Fidelis Care's Member Satisfaction Results, Measurement Year 2021

Measure	Fidelis Care Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	92%	90%
Rating of Dentist	71%	73%
Rating of Care Manager	85%	88%
Rating of Regular Visiting Nurse	87%	85%
Rating of Home Health Aide	97%	94%
Rating of Transportation Services	82%	78%
Timeliness of Home Health Aide	96%	95%
Timeliness Composite	79%	84%
Involved in Decisions	87%	83%
Manage Illness	83%	86%
Access to Routine Dental Care	33%	35%
Same Day Urgent Dental Care	19%	27%
Plan Asked to See Medicines	85%	93%
Talked About Appointing for Health Decisions	81%	77%
Document Appointing for Health Decisions	69%	63%
Plan Has Document Appointing for Health Decisions	85%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 93: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Fidelis Care exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2018-2019 review, Fidelis Care was in compliance with five standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Fidelis Care did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2018-2019 review, Fidelis Care was not in full compliance with six standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	Fidelis Care performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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 conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Hamaspik

Performance Improvement Project Findings

Table 94: Hamaspik's Performance Improvement Project Summary, Measurement Year 2021

Hamaspik's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Hamaspik aimed to reduce emergency room and hospitalization utilization by educating all members on true medical emergencies and the indicators prompting medical follow-up; outreaching to members who experienced emergency room visits and/or hospitalizations; and identifying and addressing the root causes of emergency room visits and hospitalizations. Member-Focused 2021 Interventions ▪ Educated members on the importance of consenting to the regional health information organization, annual wellness visits, and of the signs of a potentially avoidable hospitalization and appropriate action. ▪ Conducted post emergency department visit follow-up. ▪ Educated members on the importance of scheduling an appointment with their primary care provider within 14 days of hospital discharge. Provider-Focused 2021 Interventions ▪ Case managers provided primary care providers with post-discharge documents. ▪ Case managers outreached to hospital staff prior to discharge.

Table 95: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Hamaspik's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	88.90%	97.39%	86.54%	94.87%	99.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	83.30%	94.92%	95.53%	95.65%	91.70%
Potentially Avoidable Hospitalizations Rate[1]	4.35	3.13	2.68	2.72	2.20

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review

Quality-of-Care Survey Results

Table 96: Hamaspik's Member Satisfaction Results, Measurement Year 2021

Measure	Hamaspik Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	88%	90%
Rating of Dentist	79%	73%
Rating of Care Manager	90%	88%
Rating of Regular Visiting Nurse	86%	85%
Rating of Home Health Aide	94%	94%
Rating of Transportation Services	84%	78%
Timeliness of Home Health Aide	93%	95%
Timeliness Composite	85%	84%
Involved in Decisions	88%	83%
Manage Illness	86%	86%
Access to Routine Dental Care	37%	35%
Same Day Urgent Dental Care	22%	27%
Plan Asked to See Medicines	89%	93%
Talked About Appointing for Health Decisions	78%	77%
Document Appointing for Health Decisions	76%	63%
Plan Has Document Appointing for Health Decisions	80%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 97: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Hamaspik exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Hamaspik performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Hamaspik did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	Hamaspik should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 98: iCircle's Performance Improvement Project Summary, Measurement Year 2021

iCircle's Performance Improvement Project Summary
Performance Improvement Project Title: Transition of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim iCircle aimed to improve transitions of care by coordinating care and provision of services at the time of discharge; documenting receipt of inpatient discharge information within ten days of discharge; and by conducting timely face-to face assessments post-discharge for members considered high-risk for readmission. Member-Focused 2021 Interventions ▪ Described the benefits of regional health information organizations using motivational interviewing to members during home visit assessments. Managed Care Plan-Focused 2021 Interventions ▪ Employed a clinical pharmacist to conduct medication reconciliation on hospital discharges. ▪ Established a relationship with HealtheConnections by enrolling staff as HealtheConnections leads. ▪ HealtheConnections leads received alerts in the event a member was hospitalized, which prompted them to scan discharge information into TruChart which alerts the care manager.

Table 99: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

iCircle's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	20.86%	98.53%	86.26%	100.00%	95.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	25.85%	21.69%	20.48%	Not Available	100.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	12.65%	6.84%	9.62%	10.34%	<11.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 100: iCircle's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020
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: Sub-contractual 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.

Summary of 2019-2020 Results

- iCircle failed to provide evidence that the Department of Health approved a written notice advising enrollees of their disenrollment rights and their right to request information annually.
- iCircle failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- iCircle failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- iCircle failed to provide evidence of required annual vendor site visits.
- iCircle failed to provide evidence of an executed contract that includes social day care requirements.
- Two records selected for review were non-dual members transferred from a Medicaid managed care product whose documentation indicated that they did not meet the eligibility criteria for a Partial Capitation plan and were erroneously enrolled.
- 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 Partial Capitation managed care plan.
- Two records submitted for review were not signed by the enrollee or enrollee representative. In addition, one record contained an incomplete enrollment agreement that did not demonstrate 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.
- Seven records did not include evidence that the member received a copy of their current person-centered service plan.
- Seven records did not contain a current person-centered service plan within the review period.
- Nineteen (19) of 50 records did not provide evidence of a back-up plan, or the back-up provider was not appropriate.

- Nineteen (19) of 50 records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and care coordination; or contained inaccurate information.
- Twenty-six (26) 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.
- Thirteen (13) of 39 records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services did not show evidence of a signed *Acknowledgment of the Roles and Responsibilities of the Consumer/Designated Representative Form*.
- Six of 39 records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services showed evidence that the consumer direction personal assistant was the designated representative or was acting as the designated representative.
- 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 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.
- The records submitted for review failed to provide evidence that iCircle was consistently utilizing the Department of Health-approved *Model Managed Long-Term Care Extension Notice for Service Authorization, Reconsideration, and Appeals Decisions*, and failed to provide the notice of non-discrimination to enrollees.
- For 11 prior authorization and concurrent reviews following a service request, iCircle inappropriately issued multiple extension notices to enrollees.
- For seven initial adverse determination notices sent as the result of a termination, reduction, or suspension, no evidence was provided that iCircle notified the enrollee in writing of the intended action or that the notice was sent ten days prior to the intended action.
- 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.
- One record that contained an out of area disenrollment failed to show evidence that disenrollment was initiated within the required timeframe.
- 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.
- Of the 13 enrollees identified as being voluntarily or involuntarily disenrolled, four records did not include evidence that iCircle provided the proposed disenrollment date in writing to the enrollee prior to the effective date of disenrollment.

Quality-of-Care Survey Results

Table 101: iCircle's Member Satisfaction Results, Measurement Year 2021

Measure	iCircle Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	92%	90%
Rating of Dentist	67%	73%
Rating of Care Manager	92%	88%
Rating of Regular Visiting Nurse	82%	85%
Rating of Home Health Aide	95%	94%
Rating of Transportation Services	87%	78%
Timeliness of Home Health Aide	92%	95%
Timeliness Composite	80%	84%
Involved in Decisions	90%	83%
Manage Illness	83%	86%
Access to Routine Dental Care	39%	35%
Same Day Urgent Dental Care	23%	27%
Plan Asked to See Medicines	90%	93%
Talked About Appointing for Health Decisions	64%	77%
Document Appointing for Health Decisions	70%	63%
Plan Has Document Appointing for Health Decisions	75%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 102: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	iCircle exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019-2020 review, iCircle was in compliance with four standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	iCircle performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019-2020 review, iCircle was not in full compliance with seven standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	iCircle performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	iCircle should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2019-2020 compliance findings. iCircle should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Integra

Performance Improvement Project Findings

Table 103: Integra's Performance Improvement Project Summary, Measurement Year 2021

Integra's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Integra aimed to improve transitions of care by providing appropriate coordination of care and discharge planning. Member-Focused 2021 Interventions ▪ Identified members assessed as "at risk" for rehospitalization and created individualized treatment plans to address increased rehospitalization risk. ▪ Assisted members with making follow-up primary care provider appointments after completing the post-discharge questionnaire. ▪ Addressed any social determinants of health identified through the completion of the post-discharge questionnaire or in the review of the post-discharge Uniform Assessment System for New York Community Health Assessments. Provider-Focused 2021 Interventions ▪ Notified primary care providers of medication discrepancies identified during Uniform Assessment System for New York Community Health Assessment medication reconciliations. Managed Care Plan-Focused 2021 Interventions ▪ Increased communication between the managed care plan and facilities to facilitate successful acquisition of discharge paperwork. ▪ Increased communication between care management and Uniform Assessment System for New York Community Health Assessment operations team to facilitate discharge documentation exchange, including medication lists for medication reconciliation. ▪ Notified care management of medication discrepancies identified during Uniform Assessment System for New York Community Health Assessment medication reconciliations. ▪ Implemented a new process to identify the percentage of all admissions with timely notification to the managed care plan compared to total admissions identified in admission, discharge, and transfer encounter reports. ▪ Revised the electronic medical record to capture inpatient stay information. ▪ Edited the post-discharge questionnaire to include a "risk for rehospitalization" methodology.

Table 104: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Integra's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	Not Available	Not Available	86.78%	94.15%	80.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[2]	Not Available	Not Available	87.67%	Not Available	90.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[3]	19.91%	23.21%	13.97%	14.62%	15.00%

[1] The measurement period for the 2020 rate reported for *Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge* and *Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment* is May to December of the measurement year.

[2] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[3] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 105: Integra's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2018-2019
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	NC
438.230: Sub-contractual 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.

Summary of 2018-2019 Results

- Integra did not provide evidence of the presentation and approval of an annual budget for 2019 before the board of directors.
- Integra failed to provide evidence that enrollees were notified in writing of disenrollment rights and their right to request information annually.
- Integra failed to produce evidence of vendor oversight for social day care providers to assure compliance with *9 New York Codes, Rules and Regulations 6654.20*.
- Integra failed to provide executed contracts between the managed care plan and the social day care provider that included required provisions.
- Integra failed to provide evidence of annual written notification to members of updates to the provider directory.
- Integra's Fraud, Waste, and Abuse Hotline telephone number was a non-working number.
- Of the 14 records pertaining to non-dual enrollees, three contained 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 Partially Capitated managed care plan.
- Fourteen (14) of 50 records did not include a completed enrollment agreement or contain pre-filled content not completed by the enrollee.
- Twenty-nine (29) of 50 records did not include evidence that enrollees were provided with written notification of the person-centered service plan.
- Thirty-three (33) of 50 records contained current person-centered service plans that did not consistently indicate the scope of services. In addition, the frequency of services was not documented in easily understood language and format.
- Forty-nine (49) of 50 records did not contain a completed back-up plan form. Additionally, 48 records contained a back-up care plan form that indicated that the services to be provided by the caregiver were in Sections 1(e) and (f)"; however, sections 1(e) and (f) were not found in the document and or in the template approved by the Department of Health on January 9, 2018.
- Of the 32 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, six showed evidence that the consumer directed personal assistant was the designated representative or was acting as the designated representative.
- Fourteen (14) of 50 records contained information that was inconsistent or inaccurate when compared to other care management notes or other documentation contained in the record including but not limited to the plan of care, the community health assessment, notices to the member and/or disenrollment documentation.
- Fifteen (15) of 50 records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care.
- For 13 appeals of decisions resulting from a concurrent review, no evidence was provided that the managed care plan 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.
- Of the seven initial adverse determination notices sent as the result of a termination, reduction, or suspension, four did not show evidence that the notice was sent ten days prior to the effective date of the intended action.
- All final adverse determination notices on file, where the denial was based on medical necessity, did not contain procedures for filing an external appeal. Specifically, there was no evidence that an external appeal application was attached to the notice.
- For 29 prior authorization and concurrent reviews following a service request, no evidence was provided that the managed care plan either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.

- Of the six enrollees identified as being voluntarily/involuntarily disenrolled, two records did not include evidence that the managed care plan provided the proposed disenrollment date in writing to the enrollee prior to the effective date of disenrollment.

Quality-of-Care Survey Results

Table 106: Integra's Member Satisfaction Results, Measurement Year 2021

Measure	Integra Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	93%	90%
Rating of Dentist	73%	73%
Rating of Care Manager	91%	88%
Rating of Regular Visiting Nurse	93%	85%
Rating of Home Health Aide	97%	94%
Rating of Transportation Services	79%	78%
Timeliness of Home Health Aide	99%	95%
Timeliness Composite	88%	84%
Involved in Decisions	87%	83%
Manage Illness	89%	86%
Access to Routine Dental Care	36%	35%
Same Day Urgent Dental Care	39%	27%
Plan Asked to See Medicines	95%	93%
Talked About Appointing for Health Decisions	77%	77%
Document Appointing for Health Decisions	47%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 107: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Integra exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2018-2019 review, Integra was in compliance with six standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Integra performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction.	X	X	
Opportunities for Improvement				
Performance Improvement Project	None.			
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2018-2019 review, Integra was not in full compliance with five standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	Integra performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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.	X	X	X
Compliance with Federal Managed Care 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 conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 108: Kalos Health's Performance Improvement Project Summary, Measurement Year 2021

Kalos Health's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Kalos Health aimed to reduce emergency room and hospitalization utilization by conducting registered nurse-led assessments for care management and home health linkages and by holding inclusive interdisciplinary team meetings. Member-Focused 2021 Interventions ▪ Conducted registered nurse care management assessments to improve assessment of clinical needs. ▪ Conducted health home linkage assessments to improve the identification of available interdisciplinary resources. ▪ Provided members with educational materials, relevant to the members' inpatient encounter diagnoses, to increase member awareness of which clinical indicators to monitor and when to take appropriate follow-up action. Provider-Focused 2021 Interventions ▪ Conducted inclusive interdisciplinary team meetings with the member, managed care plan clinical staff, primary care or health home staff, and third-party insurance clinical staff to increase communication and collaboration. ▪ Outreached to providers and practices treating a disproportionate number of members with repeat inpatient utilization.

Table 109: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Kalos Health's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[1]	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021[1]	Target Rate
Percentage of Members Without a Hospital Stay in the Last 90 Days	85.48%	88.41%	86.04%	81.73%	94.10%
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	87.70%	87.85%	87.53%	84.70%	92.10%
Potentially Avoidable Hospitalizations Rate[2]	5.70	4.57	1.99	2.98	4.56

[1] The measurement period for the 2018, 2019, 2020, and 2021 rates reported for *Percentage of Members Without an Emergency Room Visit in the Last 90 Days* and *Percentage of Members Without a Hospital Stay in the Last 90 Days* is July to December of the measurement year.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 110: Kalos Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2021-2022
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: Sub-contractual 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.

Summary of 2021-2022 Results

- Kalos Health failed to provide evidence that credentialing and re-credentialing are performed on participating providers on a periodic basis (initially and not less than once every three years) and for monitoring provider performance. *(Contract Article VII Section C. 1)*
- Kalos Health failed to provide evidence that monitoring of providers is performed for fiscal intermediaries. *(Contract Article V11 Section A.1, Section C. 1)*
- Documentation provided by Kalos Health identified failure to routinely comply with the plan enrollment denial process. *(Contract Article V B.3.b, C.2)*
- 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. *(Contract Article V H.5)*
- The majority of person-centered service plans on record did not consistently indicate the scope, duration, and frequency of services, or services were not documented in easily understood language and format. *(Contract Article V J.1, J.9.c.vii)*
- Four records that contained initial adverse determination denial notices were not sent within the required timeframe. *(Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements)*
- 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. *(Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements)*
- 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. *(Contract Appendix K: Grievance System, Member Handbook Language and Service Authorization Requirements)*

- 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. *(Contract Article V D.1.e)*
- Kalos Health failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*. *(Contract Article VII Section C.2 (a))*
- Kalos Health failed to provide evidence of required annual vendor site visits. *(Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20, Contract Article VII Section C.2 (a))*
- Kalos Health failed to provide executed contracts between Kalos Health and the social day care provider that included required provisions. *(Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20, Contract Article VII Section C.2 (a))*
- Documentation provided by Kalos Health identified failure to routinely comply with the Conflict Free Evaluation and Enrollment Center dispute resolution process to resolve eligibility discrepancies. *(Contract Article IV E.3, Policy 16.03: Conflict Free Evaluation and Enrollment Center Dispute Resolution, Policy 15.08: Conflict-Free Evaluation and Enrollment Center Dispute Resolution)*
- Forty (40) records did not contain a written back-up plan, or the back-up plan was incomplete. *(Contract Article V J.9.c.vi)*
- Thirty (30) records lacked evidence of monthly contact with the member. *(Contract Article V J.6.a.)*

Quality-of-Care Survey Results

Table 111: Kalos Health's Member Satisfaction Results, Measurement Year 2021

Measure	Kalos Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	79%	90%
Rating of Dentist	72%	73%
Rating of Care Manager	83%	88%
Rating of Regular Visiting Nurse	72%	85%
Rating of Home Health Aide	77%	94%
Rating of Transportation Services	75%	78%
Timeliness of Home Health Aide	89%	95%
Timeliness Composite	78%	84%
Involved in Decisions	76%	83%
Manage Illness	80%	86%
Access to Routine Dental Care	33%	35%
Same Day Urgent Dental Care	14%	27%
Plan Asked to See Medicines	92%	93%
Talked About Appointing for Health Decisions	65%	77%
Document Appointing for Health Decisions	84%	63%
Plan Has Document Appointing for Health Decisions	87%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 112: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Kalos Health exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2021-2022 review, Kalos Health was in compliance with six standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Kalos Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Kalos Health did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
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 Subpart D.*	X	X	X
Quality-of-Care Survey	Kalos Health performed significantly worse than the Medicaid Managed Long-Term Care program on six measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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.	X	X	X
Compliance with Federal Managed Care Standards	Kalos Health should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 113: MetroPlus's Performance Improvement Project Summary, Measurement Year 2021

MetroPlus's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim MetroPlus aimed to reduce emergency room and hospitalization utilization by identifying members with emergency department visits and/or hospital admissions through the Uniform Assessment System for New York; training nurses to identify potentially avoidable hospitalization events while reviewing discharge summaries; conducting member education; and by logging all emergency room visits and hospital admissions. Member-Focused 2021 Interventions ▪ In welcome and monthly calls, case mangers reinforced the responsibility of members and caregivers to report any emergency room visits or hospital admission to the case management registered nurse or to the managed care plan. ▪ Identified members with potentially avoidable hospitalizations monthly through the Uniform Assessment System for New York Community Health Assessment ad hoc reports and provided the case management registered nurses with a list of members who were identified with potentially avoidable hospitalizations for member follow-up and education. Provider-Focused 2021 Interventions ▪ Informed all contract vendors for personal care assistants on the process of timely reporting of any member emergency room visits or hospital admissions. ▪ Provided in-service to assessment registered nurses and case managers regarding emergency room visits and hospital admissions assessments. Managed Care Plan-Focused 2021 Interventions ▪ Maintained a monthly log of members identified with emergency room visits and/or hospitalizations with reasons for the visit or admission and recorded the date of education and disease topics provided to members. ▪ Community health assessment reviewers checked that emergency room visits and hospital admissions in the Uniform Assessment System for New York were documented daily in the emergency room visits and hospitalization log maintained by the case management team and informed the assessment registered nurse of any corrections within two days from the date of assessment.

Table 114: MetroPlus's Performance Improvement Project Indicators, Measurement Years 2018 to 2021

MetroPlus's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	93.71%	93.83%	Not Available	Not Available	95.60%
Percentage of Members Without a Hospital Stay in the Last 90 Days	89.18%	89.92%	Not Available	Not Available	91.20%
Potentially Avoidable Hospitalizations Rate[1]	4.93	1.51	0.00	0.02	1.51

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 115: MetroPlus's Member Satisfaction Results, Measurement Year 2021

Measure	MetroPlus Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	83%	90%
Rating of Dentist	75%	73%
Rating of Care Manager	86%	88%
Rating of Regular Visiting Nurse	82%	85%
Rating of Home Health Aide	93%	94%
Rating of Transportation Services	70%	78%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	80%	84%
Involved in Decisions	84%	83%
Manage Illness	92%	86%
Access to Routine Dental Care	32%	35%
Same Day Urgent Dental Care	18%	27%
Plan Asked to See Medicines	89%	93%
Talked About Appointing for Health Decisions	72%	77%
Document Appointing for Health Decisions	59%	63%
Plan Has Document Appointing for Health Decisions	71%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 116: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	MetroPlus exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	MetroPlus was unable to report 2020 and 2021 rates for the *Percentage of Members Without an Emergency Room Visit in the Last 90 Days* indicator and the *Percentage of Members Without a Hospital Stay in the Last 90 Days* indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	MetroPlus performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	point of measurement for the performance indicators.			
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 outcomes of the assessment moratorium.	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
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 117: Montefiore's Performance Improvement Project Summary, Measurement Year 2021

Montefiore's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Montefiore aimed to reduce emergency room and hospitalization utilization by enhancing member education, developing a gaps in care report, and by implementing a care team alert system for admissions, discharges, and transfers. Member-Focused 2021 Interventions ▪ Educated members on how to access urgent care centers through monthly care management calls. ▪ Enhanced written materials and reviewed appropriateness of use of care settings. ▪ Improved member and case management education on common symptoms, severity, and where to seek appropriate care. ▪ Educated members via monthly calls and reinforced the availability of case management with all oral and written communication to members. ▪ Assisted members with primary care provider appointment scheduling and encouraged use of urgent care when primary care provider same-day or near-term visits were unavailable during case management interactions and monthly calls. ▪ Encouraged member use of patient portal to schedule primary care provider appointments, access lab and medication information, and other care alerts. ▪ Obtained and confirmed member's preferred address and contact information during monthly calls to ensure primary form of contact for mailings, education, and other materials. Provider-Focused 2021 Interventions ▪ Reviewed quality and performance activities monthly with providers rendering care to members. ▪ Started a licensed home care services agency collaborative group to implement standard best practices, tools, and improvement activities. ▪ Implemented a value-based payment incentive program that rewarded high performance and encouraged engagement and adoption of plan's improvement tools. ▪ Initiated tracking of members in regional health information organization and admission, discharge, and transfer data exchange platform to allow plan to report and monitor potentially avoidable hospitalizations and emergency department visits and to send care team use as well as to send notifications/alerts for clinical interventions and post-discharge follow-up.

Table 118: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Montefiore's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[2]	Interim Rate Measurement Year 2020[2]	Final Rate Measurement Year 2021[2]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	92.79%	89.44%	Not Available	69.41%	≥ 95.20%
Percentage of Members Without a Hospital Stay in the Last 90 Days	83.73%	81.83%	Not Available	76.45%	≥ 88.30%
Potentially Avoidable Hospitalizations Rate[3]	2.44	2.75	3.80	3.98	≤ 3.40

[1] The measurement period for 2018 is January to June of the measurement year.

[2] The measurement period for the 2019, 2020, and 2021 rates reported for *Percentage of Members Without an Emergency Room Visit in the Last 90 Days* and *Percentage of Members Without a Hospital Stay in the Last 90 Days* is July to December of the measurement year.

[3] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 119: Montefiore's Member Satisfaction Results, Measurement Year 2021

Measure	Montefiore Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	94%	90%
Rating of Dentist	76%	73%
Rating of Care Manager	92%	88%
Rating of Regular Visiting Nurse	83%	85%
Rating of Home Health Aide	96%	94%
Rating of Transportation Services	80%	78%
Timeliness of Home Health Aide	98%	95%
Timeliness Composite	85%	84%
Involved in Decisions	84%	83%
Manage Illness	91%	86%
Access to Routine Dental Care	37%	35%
Same Day Urgent Dental Care	19%	27%
Plan Asked to See Medicines	97%	93%
Talked About Appointing for Health Decisions	80%	77%
Document Appointing for Health Decisions	70%	63%
Plan Has Document Appointing for Health Decisions	91%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 120: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Montefiore performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Montefiore did not meet the target rate for any performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	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.	X	X	X

Nascentia

Performance Improvement Project Findings

Table 121: Nascentia's Performance Improvement Project Summary, Measurement Year 2021

Nascentia's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Nascentia aimed to reduce emergency room and hospitalization utilization by increasing timely follow-up, implementing care coordination, and by educating members. Member-Focused 2021 Interventions ▪ Educated members on the importance of following-up with primary care providers and other pertinent specialists for management of comorbidities that put members at-risk for frequent emergency room visits. Managed Care Plan-Focused 2021 Interventions ▪ Accessed regional health information organizations to assist with providing timely follow-up on hospital admission to allow for adequate discharge planning. ▪ Obtained discharge summary to assure all discharge orders and recommended follow-up is complete to avoid rehospitalization and repeat emergency room usage.

Table 122: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Nascentia's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	90.39%	92.35%	88.48%	86.34%	95.40%
Percentage of Members Without a Hospital Stay in the Last 90 Days	86.40%	88.19%	82.88%	78.42%	90.00%
Potentially Avoidable Hospitalizations Rate[1]	4.40	3.48	3.29	4.52	3.20

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 123: Nascentia's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
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: Sub-contractual 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.

Summary of 2020-2021 Results

- Nascentia failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- Nascentia failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- Nascentia failed to provide evidence of required annual vendor site visits.
- Nascentia failed to provide executed contracts between Nascentia and the social day care provider that included required provisions.
- 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.
- Records submitted for review did not include evidence that enrollees were provided with written notification of the person-centered service plan.
- Sixteen (16) of 50 records did not include a back-up plan or the back-up plan was incomplete.
- Eighteen (18) records that indicated that the enrollee was 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.
- Six of 50 records lacked evidence of monthly contact with the member.
- For nine prior authorization or concurrent reviews following a service request, no evidence was provided that Nascentia either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.
- For six initial adverse determination notices sent as the result of a termination, reduction or suspension, no evidence was provided that Nascentia either notified the enrollee in writing of the intended action or that the notice was sent within the required time prior to the effective date of the intended action.
- Eleven (11) 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.
- 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.

Quality-of-Care Survey Results

Table 124: Nascentia's Member Satisfaction Results, Measurement Year 2021

Measure	Nascentia Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	91%	90%
Rating of Dentist	77%	73%
Rating of Care Manager	86%	88%
Rating of Regular Visiting Nurse	79%	85%
Rating of Home Health Aide	95%	94%
Rating of Transportation Services	80%	78%
Timeliness of Home Health Aide	98%	95%
Timeliness Composite	80%	84%
Involved in Decisions	87%	83%
Manage Illness	91%	86%
Access to Routine Dental Care	46%	35%
Same Day Urgent Dental Care	38%	27%
Plan Asked to See Medicines	93%	93%
Talked About Appointing for Health Decisions	67%	77%
Document Appointing for Health Decisions	76%	63%
Plan Has Document Appointing for Health Decisions	73%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.
Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 125: Nascentia's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Nascentia measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Nascentia was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Nascentia performed significantly better than the Medicaid Managed Long-Term Care	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	program on one measure of member satisfaction.			
Opportunities for Improvement				
Performance Improvement Project	Nascentia did not meet the target rate for any performance indicator.	X	X	X
Performance Measures	None.			
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 Subpart D.*	X	X	X
Quality-of-Care Survey	Nascentia performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	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.	X	X	X

Prime Health

Performance Improvement Project Findings

Table 126: Prime Health's Performance Improvement Project Summary, Measurement Year 2021

Prime Health's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Prime Health aimed to reduce emergency room and hospitalization utilization by educating staff and members, assisting members with finding appropriate providers, and strengthening clinician collaboration. Member-Focused 2021 Interventions ▪ Clinicians reviewed high-risk medications with members/caregivers to ensure compliance during enrollment and reassessment visits. ▪ Provided disease management strategies to members/caregivers or authorized representatives. ▪ Reviewed high-risk medications with members/caregivers during the monthly phone call and post-hospitalizations to reconcile pre- and post-discharge medication lists. ▪ Educated all members on potentially avoidable hospitalizations. ▪ Case managers made follow-up phone calls within seven days after the initial enrollment or hospitalization. Managed Care Plan-Focused 2021 Interventions ▪ Coordinated care and alternative care planning following an emergency room visit or hospitalization.

Table 127: Prime Health's Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Prime Health's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[2]	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	87.58%	84.78%	95.55%	89.21%	92.30%
Percentage of Members Without a Hospital Stay in the Last 90 Days	71.34%	81.40%	95.21%	86.12%	90.00%
Potentially Avoidable Hospitalizations Rate[3]	4.64	3.89	4.22	5.38	4.00

[1] The measurement period for 2018 is January to June of the measurement year.

[2] The measurement period for 2019 is July to December of the measurement year.

[3] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 128: Prime Health's Member Satisfaction Results, Measurement Year 2021

Measure	Prime Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	84%	90%
Rating of Dentist	77%	73%
Rating of Care Manager	78%	88%
Rating of Regular Visiting Nurse	70%	85%
Rating of Home Health Aide	90%	94%
Rating of Transportation Services	81%	78%
Timeliness of Home Health Aide	94%	95%
Timeliness Composite	78%	84%
Involved in Decisions	87%	83%
Manage Illness	77%	86%
Access to Routine Dental Care	36%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%
Plan Asked to See Medicines	94%	93%
Talked About Appointing for Health Decisions	59%	77%
Document Appointing for Health Decisions	59%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 129: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Prime Health did not meet the target rate for any performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Prime Health performed significantly worse than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
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
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 130: RiverSpring's Performance Improvement Project Summary, Measurement Year 2021

RiverSpring's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim RiverSpring aimed to improve transitions of care by standardizing the process to request a discharge summary, developing clinical criteria for post-discharge assessments, contacting members within 48-hours post-discharge, and by assisting members with scheduling follow-up. Member-Focused 2021 Interventions ▪ Outreached to member, or representative, within 48 hours of discharge notification to provide instructions and assistance as needed. ▪ Evaluated the clinical criteria of members to determine if a post-discharge Uniform Assessment System for New York Community Health Assessment was needed. ▪ Assisted members in scheduling follow-up appointments within one week of discharge. Managed Care Plan-Focused 2021 Interventions ▪ Implemented a standardized process for requesting discharge summaries.

Table 131: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

RiverSpring's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	17.39%	65.68%	62.86%	54.61%	65.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	52.45%	63.48%	55.70%	Not Available	64.50%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	25.23%	23.72%	20.52%	24.10%	19.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 132: RiverSpring's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020
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: Sub-contractual 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.

Summary of 2020 Results

- RiverSpring failed to provide evidence of annual written notification to members of updates to the provider directory.
- 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.
- RiverSpring failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- RiverSpring failed to provide evidence of required annual vendor site visits.
- RiverSpring failed to accurately maintain the Uniform Assessment System for New York Community Health Assessment case list.
- Two of 50 records lacked timely reassessments during the review period.
- Plans of care on record did not consistently indicate the scope of services or include all authorized services. In addition, eight current plans of care contained incomplete information.
- Of the 15 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services, 12 records did not contain a physician's order template that was approved by the Department of Health.
- Twenty-two (22) of 50 records contained 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 document member service requests and/or appeals.
- Ten of 50 records lacked evidence of monthly contact with the member.
- 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.

- For 11 initial adverse determination notices sent as the result of a termination, reduction or suspension, evidence was not provided that RiverSpring either notified the enrollee in writing of the intended action or that the notice was sent within the required time prior to the effective date of the intended action.
- For three records that contained an involuntary disenrollment, evidence was not provided that RiverSpring initiated disenrollment within the required timeframe.

Quality-of-Care Survey Results

Table 133: RiverSpring's Member Satisfaction Results, Measurement Year 2021

Measure	RiverSpring Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	94%	90%
Rating of Dentist	78%	73%
Rating of Care Manager	98%	88%
Rating of Regular Visiting Nurse	95%	85%
Rating of Home Health Aide	98%	94%
Rating of Transportation Services	82%	78%
Timeliness of Home Health Aide	100%	95%
Timeliness Composite	95%	84%
Involved in Decisions	84%	83%
Manage Illness	83%	86%
Access to Routine Dental Care	54%	35%
Same Day Urgent Dental Care	39%	27%
Plan Asked to See Medicines	97%	93%
Talked About Appointing for Health Decisions	70%	77%
Document Appointing for Health Decisions	43%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 134: RiverSpring's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	RiverSping's measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020 review, RiverSpring was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	RiverSpring performed significantly better than the Medicaid Managed Long-Term Care program on eight measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	RiverSpring did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020 review, RiverSpring was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	RiverSpring performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
Performance Measures	RiverSpring should evaluate the impact of the community health reassessment moratorium on the health of its	X	X	X

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

Senior Health Partners

Performance Improvement Project Findings

Table 135: Senior Health Partners's Performance Improvement Project Summary, Measurement Year 2021

Senior Health Partners's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Senior Health Partners aimed to reduce emergency room and hospitalization utilization by implementing information technology-based processes for early identification of members in emergency departments and/or hospitals; facilitating enhanced care coordination services and discharge planning; timely referrals to primary and/or specialty care providers; notifying primary care providers of their patients identified as high utilizers of emergency departments and hospitals; and by providing members with education and resources. Member-Focused 2021 Interventions ▪ Case managers assisted with discharge planning and outreached members within three business days after receiving the discharge notification of an emergency department visit or hospitalization. ▪ Case managers proactively evaluated members for at-risk status for falls, polypharmacy, urinary incontinence, pain, influenza, pneumonia, and depression during their monthly outreach calls and provided the necessary interventions (i.e., education, referrals) that will keep them healthy in the community. ▪ Developed enhanced internal processes, clinical assessment tools, and automated/integrated reports to improve the early identification and timely care coordination of members post-discharge from an emergency department, inpatient facility, or of members who are at-risk for a potentially avoidable hospitalization. Provider-Focused 2021 Interventions ▪ Case managers linked members to primary and/or specialty care within 30 days from discharge notification and made referrals to community-based services as appropriate. Managed Care Plan-Focused 2021 Interventions ▪ Established a health information exchange, triggered by emergency department visits and inpatient hospitalizations, between hospital systems and Senior Health Partners.

Table 136: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Senior Health Partners's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019[1]	Interim Rate Measurement Year 2020[1]	Final Rate Measurement Year 2021[1]	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	92.59%	93.49%	95.02%	92.32%	93.20%
Percentage of Members Without a Hospital Stay in the Last 90 Days	89.55%	90.48%	87.89%	80.57%	90.30%
Potentially Avoidable Hospitalizations Rate[2]	4.73	4.24	3.87	3.29	4.49

[1] The measurement period for 2018, 2019, 2020, and 2021 is July to December of the measurement year.
[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 137: Senior Health Partners Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2018-2019
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: Sub-contractual 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.

Summary of 2018-2019 Results

- Senior Health Partners failed to provide evidence that enrollees were notified in writing of disenrollment rights and their right to request information annually.
- Senior Health Partners failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- Senior Health Partners failed to produce evidence of vendor oversight for social day care providers to assure compliance with *9 New York Codes, Rules and Regulations 6654.20*.
- Senior Health Partners failed to provide evidence of required annual vendor site visits.

- Senior Health Partners failed to provide executed contracts between the managed care plan and the social day care provider that included required provisions.
- Senior Health Partners failed to accurately maintain the Uniform Assessment System for New York Community Health Assessment case list.
- Of the 11 records pertaining to non-dual enrollees, three 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 Partially Capitated managed care plan.
- One record submitted for review contained an incomplete enrollment agreement that did not demonstrate that the enrollee received all materials required on enrollment.
- Ten of 50 records lacked timely reassessments.
- Current person-centered service plans on record lacked member specific detail and included inaccurate and/or inappropriate information that did not pertain to the member. In addition, person centered service plans did not consistently indicate the scope, duration, and frequency of services.
- Back-up plans on record lacked member specific detail and included inaccurate and/or inappropriate information that did not pertain to the member.
- Of the 17 records that indicated that the enrollee was receiving Consumer Directed Personal Assistance Services ten did not contain current physician orders.
- Of the 17 records that indicated the enrollee was receiving Consumer Directed Personal Assistance Services, one showed evidence that the consumer directed personal assistant was the enrollee's spouse, and four indicated the consumer directed personal assistant was the documented designated representative or was acting as the designated representative.
- Of the 11 records where a grievance was identified, three records did not contain acknowledgement or determination notices to enrollees for those grievances that could not be resolved immediately.
- Of the 12 records that contained initial adverse determination denial notices, five were not sent within the required timeframe.
- One record reviewed indicated that the managed care plan failed to appropriately assess an enrollee following a change in condition related to an inpatient admission.
- Of the 10 records that indicate the enrollee was involuntary disenrolled, two indicated that the managed care plan failed to provide written notice of the intent to disenroll prior to the proposed disenrollment date as part of the enrollee record.

Quality-of-Care Survey Results

Table 138: Senior Health Partners's Member Satisfaction Results, Measurement Year 2021

Measure	Senior Health Partners Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	93%	90%
Rating of Dentist	81%	73%
Rating of Care Manager	86%	88%
Rating of Regular Visiting Nurse	83%	85%
Rating of Home Health Aide	98%	94%
Rating of Transportation Services	72%	78%
Timeliness of Home Health Aide	100%	95%
Timeliness Composite	81%	84%
Involved in Decisions	83%	83%
Manage Illness	86%	86%
Access to Routine Dental Care	33%	35%
Same Day Urgent Dental Care	32%	27%
Plan Asked to See Medicines	95%	93%
Talked About Appointing for Health Decisions	84%	77%
Document Appointing for Health Decisions	81%	63%
Plan Has Document Appointing for Health Decisions	82%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 139: Senior Health Partners's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Senior Health Partners's measurement year 2021 performance improvement project passed validation.	X	X	X
	Senior Health Partners exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2018-2019 review, Senior Health Partners was in compliance with four standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Senior Health Partners performed significantly better than the Medicaid Managed Long-	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Term Care program on three measures of member satisfaction.			
Opportunities for Improvement				
Performance Improvement Project	Senior Health Partners did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2018-2019 review, Senior Health Partners was not in full compliance with seven standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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 Health Partners should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Senior Network Health

Performance Improvement Project Findings

Table 140: Senior Network Health's Performance Improvement Project Summary, Measurement Year 2021

Senior Network Health's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Senior Network Health aimed to improve transitions of care by improving the communication and processing of inpatient discharge information, and by coordinating care of services at the time of discharge. Member-Focused 2021 Interventions ▪ Educated members on the importance of regional health information organizations to encourage member participation. ▪ Assisted members with scheduling a follow-up appointment with their primary care provider within 14 days of discharge. ▪ Contacted members after their primary care provider appointments to confirm attendance and determine if there are any changes that may impact the member's plan of care. Provider-Focused 2021 Interventions ▪ Within ten days post-discharge, obtained discharge documentation from the discharging facility's medical records department directly when documentation was not available via the regional health information organization. ▪ Notified providers through fax when a member was discharged, with facility name and dates of admission, discharge diagnosis, and discharge summary documentation when available.

Table 141: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Senior Network Health's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	23.18%	81.38%	58.59%	82.14%	85.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	65.45%	80.57%	78.49%	Not Available	90.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	23.64%	25.91%	18.59%	22.14%	10.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.
[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 142: Senior Network Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
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: Sub-contractual 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.

Summary of 2020-2021 Results

- Senior Network Health failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- Senior Network Health failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- Senior Network Health failed to provide evidence of required annual vendor site visits.
- Senior Network Health failed to provide evidence of an executed contract that included social day care requirements.
- Records that indicated that 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.
- Eight records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services did not show evidence of a signed *Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative Form*.
- Three records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services showed evidence that the consumer directed personal assistant was the designated representative or was acting as the designated representative.
- Three records lacked evidence of monthly communication with the member.
- 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.
- For two initial adverse determination notices sent as the result of a member-initiated termination reduction, no evidence was provided that Senior Network Health notified enrollee in writing of the intended action.

Quality-of-Care Survey Results

Table 143: Senior Network Health's Member Satisfaction Results, Measurement Year 2021

Measure	Senior Network Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	88%	90%
Rating of Dentist	77%	73%
Rating of Care Manager	89%	88%
Rating of Regular Visiting Nurse	95%	85%
Rating of Home Health Aide	100%	94%
Rating of Transportation Services	83%	78%
Timeliness of Home Health Aide	98%	95%
Timeliness Composite	92%	84%
Involved in Decisions	88%	83%
Manage Illness	90%	86%
Access to Routine Dental Care	Sample Size Too Small To Report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%
Plan Asked to See Medicines	93%	93%
Talked About Appointing for Health Decisions	67%	77%
Document Appointing for Health Decisions	77%	63%
Plan Has Document Appointing for Health Decisions	87%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 144: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, Senior Network Health was in compliance with six standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Senior Network Health performed significantly better than the Medicaid Managed Long-Term	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Care program on four measures of member satisfaction.			
Opportunities for Improvement				
Performance Improvement Project	Senior Network Health did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
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 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	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
Quality-of-Care Survey	Senior Network 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.	X	X	X

Senior Whole Health

Performance Improvement Project Findings

Table 145: Senior Whole Health's Performance Improvement Project Summary, Measurement Year 2021

Senior Whole Health's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Senior Whole Health aimed to reduce emergency room and hospitalization utilization by identify members at-risk for an emergency room visit or potentially avoidable hospitalization, implementing interventions to prevent a subsequent admission, and by ensuring members attend follow-up appointments. Member-Focused 2021 Interventions ▪ Educated members on appropriate usage of the emergency department. ▪ Outreached to members who had an emergency room visit in the last 90 days. ▪ Mailed all members a regional health information organization consent form. Provider-Focused 2021 Interventions ▪ Notified primary care providers of patient discharge from the emergency room or hospital. ▪ Distributed value-based payment incentive funds to providers meeting targets. ▪ Conducted bi-annual outreach to the top-10, high-volume providers. Managed Care Plan-Focused 2021 Interventions ▪ Trained case managers and Uniform Assessment System for New York Community Health Assessment assessors. ▪ Distributed case management panel reports weekly and identified members in need of secondary prevention.

Table 146: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Senior Whole Health's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	95.00%	95.40%	93.49%	93.64%	97.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	89.80%	90.60%	85.22%	74.64%	90.00%
Potentially Avoidable Hospitalizations Rate[1]	2.07	2.66	1.95	2.86	2.94

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 147: Senior Whole Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019-2020
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: Sub-contractual 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.

Summary of 2019-2020 Results

- Senior Whole Health did not provide evidence to support this regulatory requirement; there was no board meeting for the first quarter of 2018.
- Senior Whole Health failed to produce evidence of contracted provider credentialing requirements for background checks and checks against the Medicaid excluded provider lists.
- Senior Whole Health failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- Senior Whole Health failed to provide evidence of required annual vendor site visits.
- Senior Whole Health failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- Senior Whole Health failed to provide evidence that the Department of Health-approved written notice advising enrollees of their disenrollment rights and their right to request information annually.
- Senior Whole Health failed to accurately maintain the Uniform Assessment System for New York Community Health Assessment case list.
- Documentation provided by Senior Whole Health identified failure to routinely comply with the plan enrollment denial process.
- Documentation provided by Senior Whole Health identified failure to routinely comply with the Medicaid Managed Long-Term Care enrollment denial policy.
- Of the seven records pertaining to non-dual enrollees, two records contained 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 Medicaid Managed Long-Term Care Partial Capitation plan.
- Two of 50 records contained 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.
- Five of 50 records lacked timely reassessments during the review period.
- Current person-centered service plans on record lacked member specific detail and do not consistently indicate the scope, duration, and frequency of services.

- Twenty-six (26) of 50 records did not contain a back-up plan or the back-up plan is incomplete.
- Of the 13 records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services, six did not contain a complete and/or updated physician's order during the review period.
- Thirty (30) of 50 records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care; or contain inaccurate or inconsistent information.
- Thirty-four (34) of 50 records submitted for review lacked evidence of monthly contact with the member.
- 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.
- 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.
- For three termination, suspension, or reductions of a previously authorized service, no evidence was provided that Senior Whole Health notified the enrollee of the intended action in writing at least ten days prior.
- For ten 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.
- 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.
- 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.

Quality-of-Care Survey Results

Table 148: Senior Whole Health's Member Satisfaction Results, Measurement Year 2021

Measure	Senior Whole Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	91%	90%
Rating of Dentist	62%	73%
Rating of Care Manager	86%	88%
Rating of Regular Visiting Nurse	81%	85%
Rating of Home Health Aide	96%	94%
Rating of Transportation Services	73%	78%
Timeliness of Home Health Aide	95%	95%
Timeliness Composite	80%	84%
Involved in Decisions	77%	83%
Manage Illness	80%	86%
Access to Routine Dental Care	27%	35%
Same Day Urgent Dental Care	21%	27%
Plan Asked to See Medicines	92%	93%
Talked About Appointing for Health Decisions	78%	77%
Document Appointing for Health Decisions	80%	63%
Plan Has Document Appointing for Health Decisions	88%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 149: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019-2020 review, Senior Whole Health was in compliance with five standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Senior Whole Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Senior Whole Health did not meet the target rate for two performance indicators.	X	X	X
	Senior Whole Health selected a target rate of improvement for the Potentially Avoidable Hospitalizations indicator that was higher than Senior Whole Health's baseline rate. (A lower rate indicates better performance for the Potentially Avoidable Hospitalizations indicator.)	X	X	X
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 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
	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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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.	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
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 150: VillageCare's Performance Improvement Project Summary, Measurement Year 2021

VillageCare's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim VillageCare aimed to reduce emergency room and hospitalization utilization by implementing a transition of care case management program that focuses on improving primary care visit coordination, medication reconciliation, and involves a licensed clinical social worker to address social determinants of health. Member-Focused 2021 Interventions ▪ Provided medication reconciliation to members enrolled in the transition of care case management program. ▪ While enrolled in the transition of care case management program, facilitated follow-up appointments for members who were hospitalized within ten days of hospitalization. ▪ Outreached to members enrolled in the transition of care case management program telephonically within 30 days of enrollment.

Table 151: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

VillageCare's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	92.89%	95.75%	95.10%	95.65%	97.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	88.51%	91.01%	84.53%	82.67%	98.00%
Potentially Avoidable Hospitalizations Rate[1]	3.08	1.53	2.18	2.74	2.80

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 152: VillageCare's Member Satisfaction Results, Measurement Year 2021

Measure	VillageCare Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	90%	90%
Rating of Dentist	69%	73%
Rating of Care Manager	87%	88%
Rating of Regular Visiting Nurse	89%	85%
Rating of Home Health Aide	91%	94%
Rating of Transportation Services	79%	78%
Timeliness of Home Health Aide	96%	95%
Timeliness Composite	85%	84%
Involved in Decisions	85%	83%
Manage Illness	87%	86%
Access to Routine Dental Care	52%	35%
Same Day Urgent Dental Care	38%	27%
Plan Asked to See Medicines	93%	93%
Talked About Appointing for Health Decisions	83%	77%
Document Appointing for Health Decisions	49%	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 153: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	VillageCare exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	VillageCare performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	VillageCare did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	VillageCare performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	VillageCare should ensure its compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 154: VNS Health's Performance Improvement Project Summary, Measurement Year 2021

VNS Health's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim VNS Health aimed to improve transitions of care by facilitating the sharing of discharge documentation, conducting condition assessments post-discharge, training staff on new processes, and by developing a transition of care script designed to encourage member adherence to treatment plans. Member-Focused 2021 Interventions ▪ Educated members within 30 days of discharge on the importance of follow-up after hospitalization using an updated transition of care script. ▪ Assisted members with scheduling aftercare appointments. ▪ Within 30 days of discharge, referred members needing medication reconciliation to their primary care provider for completion. Managed Care Plan-Focused 2021 Interventions ▪ Conducted quarterly care management audits to assess transition of care workflows, specifically hospital outreach discharge summary requests, and assistance in arranging follow-up care. ▪ Implemented a process to track member attendance at post-discharge aftercare appointments.

Table 155: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

VNS Health's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	Not Available	1.89%	9.59%	16.30%	21.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	Not Available	7.54%	7.57%	Not Available	20.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	Not Available	26.80%	15.36%	11.10%	19.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 156: VNS Health's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2020-2021
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: Sub-contractual 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.

Summary of 2020-2021 Results

- VNS Health failed to provide evidence that monitoring of providers was performed for fiscal intermediaries.
- VNS Health failed to produce evidence of vendor oversight for social day care providers to assure compliance with *Title 9 New York State Official Compilation of Codes, Rules, and Regulations 6654.20*.
- VNS Health failed to provide evidence of required annual vendor site visits.
- VNS Health failed to provide evidence of an executed contract that included social day care requirements.
- Documentation provided by the managed care plan identified failure to routinely comply with the Conflict Free Evaluation and Enrollment Center dispute resolution process to resolve eligibility discrepancies.
- Fourteen (14) records contained 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. In addition, two records did not contain an enrollment agreement.
- Person-centered service plans in records did not consistently indicate the scope, duration and/or frequency of services, or lacked evidence of updated service plans.
- Twenty (20) records submitted for review did not contain a formal back-up plan or the back-up plan was incomplete.
- Seven records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services did not contain a complete physician's order or complete physician's orders for the full review period.
- Four records indicating that the enrollee was receiving Consumer Directed Personal Assistance Services showed evidence that the consumer directed personal assistant was the designated representative or was acting as the designated representative.
- Twenty-one (21) records contained care management notes that were not sufficiently detailed to demonstrate appropriate follow-up and coordination of care.
- Eighteen (18) records lacked evidence of monthly contact with the member.
- For five standard grievances, no evidence was provided that either the acknowledgement or resolution was sent within the required timeframe.

- For 25 prior authorization and concurrent reviews following a service request, no evidence was provided that VNS Health either notified the enrollee of the decision in writing or that the decision was sent within the required timeframe.
- For four initial adverse determination notices sent as the result of a termination, reduction, or suspension, VNS Health failed to notify the enrollee in writing at least ten days prior to the intended action.

Quality-of-Care Survey Results

Table 157: VNS Health's Member Satisfaction Results, Measurement Year 2021

Measure	VNS Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	82%	90%
Rating of Dentist	70%	73%
Rating of Care Manager	85%	88%
Rating of Regular Visiting Nurse	77%	85%
Rating of Home Health Aide	92%	94%
Rating of Transportation Services	77%	78%
Timeliness of Home Health Aide	97%	95%
Timeliness Composite	80%	84%
Involved in Decisions	85%	83%
Manage Illness	82%	86%
Access to Routine Dental Care	26%	35%
Same Day Urgent Dental Care	10%	27%
Plan Asked to See Medicines	90%	93%
Talked About Appointing for Health Decisions	82%	77%
Document Appointing for Health Decisions	73%	63%
Plan Has Document Appointing for Health Decisions	79%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.
Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 158: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	VNS Health exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2020-2021 review, VNS Health was in compliance with six standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	VNS Health performed significantly better than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	VNS Health did not meet the target rate for one performance indicator.	X	X	X
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 Subpart D.*	X	X	X
Quality-of-Care Survey	VNS Health performed significantly worse than the Medicaid Managed Long-Term Care program on one measure of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
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.	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
Quality-of-Care Survey	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	X	X	X

Program of All-Inclusive Care for the Elderly Managed Care Plan-Level Reporting

Performance Improvement Project Findings

Table 159: ArchCare's Performance Improvement Project Summary, Measurement Year 2021

ArchCare's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim ArchCare aimed to enhance transitions of care by improving communication between members and providers, improving care for members identified as high-risk for hospitalization, and by improving coordination of services with skilled nursing facilities. Member-Focused 2021 Interventions ▪ Educated members on the availability of 24-hour access and on-call services. ▪ Conducted assessments within first week of enrollment for new members identified as high-risk, as well as facility tours and education on the Program of All-Inclusive Care for the Elderly. Provider-Focused 2021 Interventions ▪ Educated home care service agencies on the availability of 24-hour access and on-call services. ▪ Held monthly meetings with skilled nursing facility staff to discuss admissions, mutual concerns, treatment plans, and to develop admitting protocols.

Table 160: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

ArchCare's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	63.79%	96.67%	60.88%	90.98%	90.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	67.82%	21.05%	26.18%	Not Available	85.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	17.82%	20.33%	17.65%	18.03%	16.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 161: ArchCare's Member Satisfaction Results, Measurement Year 2021

Measure	ArchCare Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	88%	90%
Rating of Dentist	63%	73%
Rating of Care Manager	75%	88%
Rating of Regular Visiting Nurse	79%	85%
Rating of Home Health Aide	97%	94%
Rating of Transportation Services	67%	78%
Timeliness of Home Health Aide	96%	95%
Timeliness Composite	88%	84%
Involved in Decisions	72%	83%
Manage Illness	82%	86%
Access to Routine Dental Care	43%	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%
Plan Asked to See Medicines	93%	93%
Talked About Appointing for Health Decisions	79%	77%
Document Appointing for Health Decisions	82%	63%
Plan Has Document Appointing for Health Decisions	93%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.
Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.
Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 162: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	ArchCare exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	ArchCare performed significantly better than the Medicaid Managed Long-Term Care program on three measures of member satisfaction	X	X	X
Opportunities for Improvement				
Performance Improvement Project	ArchCare did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	ArchCare performed significantly worse than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	health outcomes. ArchCare should also consider how to maximize realized positive outcomes of the assessment moratorium.			
Compliance with Federal Managed Care 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.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Catholic Health

Performance Improvement Project Findings

Table 163: Catholic Health's Performance Improvement Project Summary, Measurement Year 2021

Catholic Health's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Catholic Health aimed to improve transitions of care by defining a standard level of care for members discharging from a hospital or skilled nursing facility to home that ensures consistency in risk assessments, continuity of care, and linkages to optimal services to reduce readmissions. Member-Focused 2021 Interventions ▪ Conducted risk assessments for members within three days of discharge. ▪ Conducted in-person visits at member homes within 48 hours of discharge. Provider-Focused 2021 Interventions ▪ Increased communication between rehabilitation therapists and skilled nursing facility staff to ensure safe member transitions to the home setting. ▪ Implemented primary care provider discharge assessments within seven days post-discharge.

Table 164: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Catholic Health's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	100.00%	100.00%	94.29%	96.30%	100.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	Not Available	100.00%	100.00%	Not Available	90.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	0.00%	11.48%	15.63%	11.54%	0.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 165: Catholic Health's Member Satisfaction Results, Measurement Year 2021

Measure	Catholic Health Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	93%	90%
Rating of Dentist	81%	73%
Rating of Care Manager	93%	88%
Rating of Regular Visiting Nurse	97%	85%
Rating of Home Health Aide	95%	94%
Rating of Transportation Services	80%	78%
Timeliness of Home Health Aide	96%	95%
Timeliness Composite	93%	84%
Involved in Decisions	84%	83%
Manage Illness	89%	86%
Access to Routine Dental Care	Sample Size Too Small To Report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%
Plan Asked to See Medicines	94%	93%
Talked About Appointing for Health Decisions	76%	77%
Document Appointing for Health Decisions	100%	63%
Plan Has Document Appointing for Health Decisions	96%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 166: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	Catholic Health performed significantly better than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Catholic Health did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 167: CenterLight's Performance Improvement Project Summary, Measurement Year 2021

CenterLight's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim CenterLight aimed to improve transitions of care by promoting post-discharge primary care provider appointments, and by scheduling in-home nurse visits within five days of discharge for an assessment and medication reconciliation. Provider-Focused 2021 Interventions ▪ Created a requirement for the center medical director or nurse practitioner to conduct post-discharge visits when a community physician cannot comply within seven days. Managed Care Plan-Focused 2021 Interventions ▪ Extracted data from the pharmacy benefit manager of each inpatient admission to enable reconciliation at the first post-discharge visit. ▪ Developed a communication and feedback system to assure post-inpatient discharge visits with a primary care provider are scheduled within seven days post-discharge.

Table 168: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

CenterLight's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	78.72%	80.16%	71.90%	83.74%	90.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[2]	98.90%	58.61%	69.92%	Not Available	99.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[3]	21.02%	21.86%	19.23%	14.56%	17.00%

[1] The measurement period for 2018 is January to November of the measurement year.

[2] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[3] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 169: CenterLight's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	No Activity	No Activity
438.207: Assurances of Adequate Capacity and Services	C	No Activity	No Activity
438.208: Coordination and Continuity of Care	C	No Activity	No Activity
438.210: Coverage and Authorization of Services	C	No Activity	No Activity
438.214: Provider Selection	C	No Activity	No Activity
438.224: Confidentiality	C	No Activity	No Activity
438.228: Grievance and Appeal System	C	No Activity	No Activity
438.230: Sub-contractual Relationships and Delegation	C	No Activity	No Activity
438.236: Practice Guidelines	C	No Activity	No Activity
438.242: Health Information Systems	C	No Activity	No Activity
438.330: Quality Assessment and Performance Improvement Program	C	No Activity	No Activity

[1] No activity scheduled due to COVID-19.

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.

Quality-of-Care Survey Results

Table 170: CenterLight's Member Satisfaction Results, Measurement Year 2021

Measure	CenterLight Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	84%	90%
Rating of Dentist	70%	73%
Rating of Care Manager	88%	88%
Rating of Regular Visiting Nurse	87%	85%
Rating of Home Health Aide	88%	94%
Rating of Transportation Services	77%	78%
Timeliness of Home Health Aide	94%	95%
Timeliness Composite	85%	84%
Involved in Decisions	78%	83%
Manage Illness	90%	86%
Access to Routine Dental Care	37%	35%
Same Day Urgent Dental Care	20%	27%
Plan Asked to See Medicines	96%	93%
Talked About Appointing for Health Decisions	76%	77%
Document Appointing for Health Decisions	75%	63%
Plan Has Document Appointing for Health Decisions	93%	83%

Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 171: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	CenterLight exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019 review, CenterLight was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	CenterLight performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	CenterLight did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	CenterLight 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.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Complete Senior Care

Performance Improvement Project Findings

Table 172: Complete Senior Care's Performance Improvement Project Summary, Measurement Year 2021

Complete Senior Care's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Complete Senior Care aimed to improve transitions of care by implementing a change of status decision tool to inform health plan staff when a member needs an assessment. Member-Focused 2021 Interventions ▪ Educated recently discharged members on disease management. Managed Care Plan-Focused 2021 Interventions ▪ Requested inpatient discharge information prior to discharge. ▪ Notified the clinical scheduler of discharge to schedule follow-up with provider per discharge instructions.

Table 173: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Complete Senior Care's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	83.64%	80.00%	100.00%	100.00%	95.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	34.55%	40.00%	56.86%	Not Available	90.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	16.36%	40.00%	39.22%	19.15%	7.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 174: Complete Senior Care's Member Satisfaction Results, Measurement Year 2021

Measure	Complete Senior Care Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	77%	90%
Rating of Dentist	Sample Size Too Small To Report	73%
Rating of Care Manager	Sample Size Too Small To Report	88%
Rating of Regular Visiting Nurse	Sample Size Too Small To Report	85%
Rating of Home Health Aide	Sample Size Too Small To Report	94%
Rating of Transportation Services	Sample Size Too Small To Report	78%
Timeliness of Home Health Aide	Sample Size Too Small To Report	95%
Timeliness Composite	Sample Size Too Small To Report	84%
Involved in Decisions	75%	83%
Manage Illness	Sample Size Too Small To Report	86%
Access to Routine Dental Care	Sample size too small to report	35%
Same Day Urgent Dental Care	Sample Size Too Small To Report	27%
Plan Asked to See Medicines	Sample Size Too Small To Report	93%
Talked About Appointing for Health Decisions	Sample Size Too Small To Report	77%
Document Appointing for Health Decisions	Sample Size Too Small To Report	63%
Plan Has Document Appointing for Health Decisions	Sample Size Too Small To Report	83%

Sample size too small to report means that the denominator is less than 30 members.

Strengths, Opportunities for Improvement, and Recommendations

Table 175: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Complete Senior Care exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Performance Improvement Project	Complete Senior Care did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care Standards	Complete 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 by the Centers for Medicare & Medicaid Services.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Eddy SeniorCare

Performance Improvement Project Findings

Table 176: Eddy SeniorCare's Performance Improvement Project Summary, Measurement Year 2021

Eddy SeniorCare's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Eddy SeniorCare aimed to enhance transitions of care by improving communication of discharge planning with an effective plan of care to reduce the 30-day all-cause readmission rate. Member-Focused 2021 Interventions ▪ Evaluated member satisfaction, by mail survey, with care at the time of inpatient discharge. ▪ Scheduled follow-up visits based on member risk calculation at the time of inpatient discharge. Managed Care Plan-Focused 2021 Interventions ▪ Increased rate of medication reconciliation by obtaining and entering discharge documentation within 72 hours of discharge into the electronic medical record. ▪ Implemented a standardized approach mandating that post-hospital assessments take place within 72 hours of discharge, followed by a Uniform Assessment System for New York Community Health Assessment within 30 days post-discharge. ▪ Educated staff on the identification of significant change in status.

Table 177: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Eddy SeniorCare's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	77.69%	88.81%	82.01%	83.95%	90.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	72.97%	94.12%	92.95%	Not Available	90.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	25.62%	27.22%	16.91%	21.72%	< 24.32%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.

[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 178: Eddy SeniorCare's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	No Activity	No Activity
438.207: Assurances of Adequate Capacity and Services	C	No Activity	No Activity
438.208: Coordination and Continuity of Care	C	No Activity	No Activity
438.210: Coverage and Authorization of Services	C	No Activity	No Activity
438.214: Provider Selection	C	No Activity	No Activity
438.224: Confidentiality	C	No Activity	No Activity
438.228: Grievance and Appeal System	C	No Activity	No Activity
438.230: Sub-contractual Relationships and Delegation	C	No Activity	No Activity
438.236: Practice Guidelines	C	No Activity	No Activity
438.242: Health Information Systems	C	No Activity	No Activity
438.330: Quality Assessment and Performance Improvement Program	C	No Activity	No Activity

[1] No activity scheduled due to COVID-19.

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.

Quality-of-Care Survey Results

Eddy SeniorCare results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 179: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Eddy SeniorCare exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019 review, Eddy SeniorCare was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330*	X	X	X
Quality-of-Care Survey	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Performance Improvement Project	Eddy SeniorCare did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Performance Improvement Project Findings

Table 180: ElderONE's Performance Improvement Project Summary, Measurement Year 2021

ElderONE's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim ElderONE aimed to improve transitions of care by improving access to discharge information, conducting timely post-discharge assessments, and by monitoring members for 30-days post-discharge. Member-Focused 2021 Interventions ▪ Interdisciplinary team held meetings with members within three days of the member being reported as a high utilizer. Managed Care Plan-Focused 2021 Interventions ▪ Retrieved and uploaded discharge summaries from CareLink to the electronic medical record within ten days post-discharge. ▪ Monitored members who qualified for a 30-day post-discharge assessment.

Table 181: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

ElderONE's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018[1]	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	66.09%	84.11%	90.08%	88.64%	90.00%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[2]	28.75%	100.00%	98.48%	Not Available	80.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[3]	16.95%	18.46%	14.52%	21.36%	15.30%

[1] The measurement period for 2018 is January to September of the measurement year.
[2] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.
[3] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 182: ElderONE's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	No Activity	No Activity
438.207: Assurances of Adequate Capacity and Services	C	No Activity	No Activity
438.208: Coordination and Continuity of Care	C	No Activity	No Activity
438.210: Coverage and Authorization of Services	C	No Activity	No Activity
438.214: Provider Selection	C	No Activity	No Activity
438.224: Confidentiality	C	No Activity	No Activity
438.228: Grievance and Appeal System	C	No Activity	No Activity
438.230: Sub-contractual Relationships and Delegation	C	No Activity	No Activity
438.236: Practice Guidelines	C	No Activity	No Activity
438.242: Health Information Systems	C	No Activity	No Activity
438.330: Quality Assessment and Performance Improvement Program	C	No Activity	No Activity

[1] No activity scheduled due to COVID-19.

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.

Quality-of-Care Survey Results

Table 183: ElderONE's Member Satisfaction Results, Measurement Year 2021

Measure	ElderONE Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	81%	90%
Rating of Dentist	73%	73%
Rating of Care Manager	74%	88%
Rating of Regular Visiting Nurse	89%	85%
Rating of Home Health Aide	84%	94%
Rating of Transportation Services	67%	78%
Timeliness of Home Health Aide	91%	95%
Timeliness Composite	86%	84%
Involved in Decisions	79%	83%
Manage Illness	86%	86%
Access to Routine Dental Care	40%	35%
Same Day Urgent Dental Care	29%	27%
Plan Asked to See Medicines	90%	93%
Talked About Appointing for Health Decisions	83%	77%
Document Appointing for Health Decisions	92%	63%
Plan Has Document Appointing for Health Decisions	98%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 184: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019 review, ElderONE was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330*	X	X	X
Quality-of-Care Survey	ElderONE performed significantly better than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Performance Improvement Project	ElderONE did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	ElderONE performed significantly worse than the Medicaid Managed Long-Term Care program on two measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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 Medicare & Medicaid Services.	X	X	X
Quality-of-Care Survey	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.	X	X	X

Fallon Health

Performance Improvement Project Findings

Table 185: Fallon Health's Performance Improvement Project Summary, Measurement Year 2021

Fallon Health's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Fallon Health aimed to reduce emergency room and hospitalization utilization by conducting a review of all emergency room visits and hospitalizations. Member-Focused 2021 Interventions ▪ Educated members and caregivers on the risks and benefits of emergency room services after any emergency room visit. Provider-Focused 2021 Interventions ▪ Educated home health nurse coordinators on retrieving emergency room data from the electronic medical record. Managed Care Plan-Focused 2021 Interventions ▪ Educated discharge planners about the availability of in-network sub-acute and acute care providers.

Table 186: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Fallon Health's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	92.00%	90.50%	98.42%	96.08%	95.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	92.70%	89.94%	98.42%	91.50%	95.00%
Potentially Avoidable Hospitalizations Rate[1]	2.01	1.25	2.74	2.69	1.50

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Fallon Health's results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 187: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Fallon Health exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Fallon Health did not meet the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
Performance Measures	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.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	Fallon 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.	X	X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Fallon Health should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X

PACE CNY

Performance Improvement Project Findings

Table 188: PACE CNY's Performance Improvement Project Summary, Measurement Year 2021

PACE CNY's Performance Improvement Project Summary
Performance Improvement Project Title: Transitions of Care Validation Summary: There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim PACE CNY aimed to improve transitions of care by implementing a 30-day post-hospitalization follow-up protocol that includes the member. Member-Focused 2020 Intervention ▪ Implemented a 30-day follow-up protocol for members discharged from an inpatient hospital or skilled nursing facility. Provider-Focused 2020 Intervention ▪ Educated providers on the importance of following the established protocol.

Table 189: Performance Improvement Project Indicators, Measurement Years 2018 to 2021

PACE CNY's Transitions of Care Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days Post-Discharge	96.40%	94.63%	94.68%	97.82%	≥ 97.10%
Percentage of Inpatient Discharges with a Timely Post-Discharge Uniform Assessment System for New York Community Health Assessment[1]	22.62%	27.07%	Not Available	Not Available	≥ 30.00%
Percentage of Inpatient Discharges Which Resulted in Readmission Within 30 Days Post-Discharge[2]	17.74%	14.15%	17.65%	18.53%	≤ 15.00%

[1] 2021 data for this measure is not available due to a moratorium on community health reassessments put in place by the Department of Health in response to COVID-19.
[2] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Compliance review results are not available for the period under review.

Quality-of-Care Survey Results

Table 190: PACE CNY's Member Satisfaction Results, Measurement Year 2021

Measure	PACE CNY Measurement Year 2021	Medicaid Managed Long-Term Care Measurement Year 2021
Rating of Health Plan	87%	90%
Rating of Dentist	66%	73%
Rating of Care Manager	84%	88%
Rating of Regular Visiting Nurse	83%	85%
Rating of Home Health Aide	79%	94%
Rating of Transportation Services	84%	78%
Timeliness of Home Health Aide	67%	95%
Timeliness Composite	71%	84%
Involved in Decisions	90%	83%
Manage Illness	84%	86%
Access to Routine Dental Care	15%	35%
Same Day Urgent Dental Care	15%	27%
Plan Asked to See Medicines	98%	93%
Talked About Appointing for Health Decisions	84%	77%
Document Appointing for Health Decisions	87%	63%
Plan Has Document Appointing for Health Decisions	90%	83%

Red shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly worse than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant. Green shading indicates that the Medicaid Managed Long-Term Care plan's performance is significantly better than the Medicaid Managed Long-Term Care program performance. Statistically significant differences between scores were determined using z-scores. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 191: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	PACE CNY exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Managed Care Standards				
Quality-of-Care Survey	PACE CNY performed significantly better than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	PACE CNY did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	PACE CNY performed significantly worse than the Medicaid Managed Long-Term Care program on four measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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 Centers for Medicare & Medicaid Services.	X	X	X
Quality-of-Care Survey	PACE CNY 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	X	X	X

Total Senior Care

Performance Improvement Project Findings

Table 192: Total Senior Care's Performance Improvement Project Summary, Measurement Year 2021

Total Senior Care's Performance Improvement Project Summary
Performance Improvement Project Title: Emergency Department and Hospitalization Utilization Reduction **Validation Summary:** There were no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim Total Senior Care aimed to reduce emergency room and hospitalization utilization by increasing collaboration with facilities and by educating members and their families. Member-Focused 2021 Interventions ▪ Conducted one-on-one member education sessions on available levels of care and when to access emergency room services. Provider-Focused 2021 Interventions ▪ Educated providers on protocols for acute medical concerns.

Table 193: Total Senior Care's Performance Improvement Project Indicators, Measurement Years 2018 to 2021

Total Senior Care's Emergency Department and Hospitalization Utilization Rates					
Performance Indicators	Baseline Rate Measurement Year 2018	Interim Rate Measurement Year 2019	Interim Rate Measurement Year 2020	Final Rate Measurement Year 2021	Target Rate
Percentage of Members Without an Emergency Room Visit in the Last 90 Days	86.69%	86.77%	88.51%	80.66%	90.00%
Percentage of Members Without a Hospital Stay in the Last 90 Days	94.05%	93.90%	93.48%	93.20%	90.00%
Potentially Avoidable Hospitalizations Rate[1]	4.93	4.34	3.92	1.75	5.00

[1] A lower rate indicates better performance.

Performance Measure Results

Performance measure results are not available for the period under review.

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

Table 194: Total Senior Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	No Activity	No Activity
438.207: Assurances of Adequate Capacity and Services	C	No Activity	No Activity
438.208: Coordination and Continuity of Care	C	No Activity	No Activity
438.210: Coverage and Authorization of Services	C	No Activity	No Activity
438.214: Provider Selection	C	No Activity	No Activity
438.224: Confidentiality	C	No Activity	No Activity
438.228: Grievance and Appeal System	C	No Activity	No Activity
438.230: Sub-contractual Relationships and Delegation	C	No Activity	No Activity
438.236: Practice Guidelines	C	No Activity	No Activity
438.242: Health Information Systems	C	No Activity	No Activity
438.330: Quality Assessment and Performance Improvement Program	C	No Activity	No Activity

[1] No activity scheduled due to COVID-19.

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.

Quality-of-Care Survey Results

Total Senior Care results from the 2021 Member Satisfaction Survey were not published due to a small sample size.

Strengths, Opportunities for Improvement, and Recommendations

Table 195: 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 measurement year 2021 performance improvement project passed validation.	X	X	X
	Total Senior Care exceeded the target rate for two performance indicators.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	During the 2019 review, Total Senior Care was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Total Senior Care did not meet the target rate for one performance indicator.	X	X	X
Performance Measures	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	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.	X	X	X
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.	X	X	X
Compliance with Federal Managed Care 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 by the Centers for Medicare & Medicaid Services.	X	X	X
Quality-of-Care Survey	Despite its small sample size for the member satisfaction survey, Total Senior Care should evaluate member satisfaction and address adverse member experience with areas linked to quality, timeliness, and access to care.	X	X	X