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January 22, 2024

Honorable Carl Heastie
Speaker
New York State Assembly
Legislative Office Building, Room 932
Albany, New York 12248

Dear Speaker Heastie:

As Commissioned by the New York State Legislature in Section 1 of Part P of Chapter 57 of the Laws of 2022, I am pleased to submit the enclosed Final Report on Managed Care Organization Services.

Should you have further questions, please feel free to contact Mischa Sogut, Assistant Commissioner of Government Relations, at 518-473-1124 or Mischa.sogut@health.ny.gov.

Sincerely,

James V. McDonald, M.D., M.P.H.
Commissioner of Health

Enclosure

cc: Mischa Sogut

OCTOBER 2023 | THE BOSTON CONSULTING GROUP

Final Report on Managed Care Organization Services

As Commissioned by the New York State Legislature in Section 1 of Part P of Chapter 57 of the Laws of 2022

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1 ABSTRACT

New York State (NYS) has the second-largest Medicaid population in the country after California and is one of 41 states that use a Medicaid managed care model instead of a solely fee-for-service model. Managed Care Organizations (MCOs) cover approximately 80% of Medicaid enrollees in NYS, or about 6 million MCO enrollees out of a total of about 7 million NYS Medicaid members. The three largest types of MCOs are Mainstream (92% of enrollees), Health and Recovery Plans (HARP, 3%), and Managed Long-Term Care (MLTC, 5%). NYS uses an "any willing plan" certification model to authorize its MCOs to participate in the market. NYS is one of six states, of 41 with Medicaid managed care, that do not use procurement to select MCOs.

NYS's Medicaid Managed Care (MMC) program has a history of innovation resulting from the significant investment and efforts by the state over time. However, like many other MMC programs in the country, NYS's MMC program still confronts significant challenges and has opportunities for improvement. This report focuses on identifying current challenges facing the MMC program and explores potential solutions to those challenges, with a focus on contracting approach and enforcement.

This report finds that challenges are most acute within the MLTC market. Relative to peer state markets, NYS has a large number of MLTC plans, many of which have low enrollment. This combination contributes to higher administrative costs and lower profitability, higher member complaint rates, increased provider burden, and stretched state resources to effectively manage the plans. Other key issues in MLTC include limited plan integration with Medicare, subpar plan quality (particularly upstate), and challenges in measuring access and quality. Given that many challenges stem from the fragmentation of the market, using procurement as a mechanism to select the optimal number and set of plans is a potential key lever to realize change.

The NYS Mainstream market faces similar challenges in market composition. The NYS Mainstream market has more plans in the market than all but one peer state, creating pain points for members, providers, and the state. Even though, on average, the Mainstream plans outperform peer states in quality and cost, a number of plans underperform (i.e., have high cost and low quality). Driving competition and selecting the best plans through a procurement could elevate overall performance.

Looking beyond market composition to care delivery, behavioral health (BH) is the most significant challenge confronting both Mainstream and HARP. The key BH challenges are inadequate access, low utilization of BH care management models and services, and limited improvement in BH quality measures over the past several years despite continued state investment and effort. While these challenges are not solely the responsibility of managed care to solve, the current market suffers from HARP product design decisions, overlapping roles and responsibilities in care management, and difficulty with contract enforcement. Procurement would allow the state to holistically rethink the BH model within managed care.

Addressing the challenges identified in MLTC, Mainstream, and HARP will require a holistic strategy. This report focuses on three levers the state has in MCO management: selecting plans, optimizing the model contract, and enforcing the model contract through ongoing oversight of MCO performance. All three levers must work in concert to achieve desired outcomes and these levers often build on each other. For example, states use re-procurement opportunities to improve contract standards and clarify enforcement mechanisms.

Although NYS does not use procurement to select its MCOs, the state uses procurement regularly for other forms of government contracting. While the state could address MMC challenges by changing certification rules to raise performance standards, procurement is likely to be more feasible and more effective.

Based on a review of 31 Mainstream and/or MLTC procurements across 26 states since 2015, procurement provides several key advantages. First, procurement allows states to clearly communicate goals and require MCO responses. Multiple case studies show that states use procurement to directly advance their health goals. For example, expert interviews on California's 2020–2022 procurement reveal that the state considered their managed care procurement and their signature CalAIM whole-person care policy linked. California used procurement to ensure they had the right market players and contract requirements to implement the enhanced BH and social-need services that are the cornerstones of CalAIM.

Second, procurement allows the state to set an explicit target for the optimal number of plans. Sometimes, states may publicly communicate a target range or number of MCOs to be awarded contracts either statewide or per region. For example, of five procurements explored in detailed case studies, three—Indiana MLTSS, Ohio Mainstream, and Pennsylvania MLTSS—set and communicated an explicit target number of MCOs.

Third, states use procurement as a competitive tool to select the top-performing plans, regularly test the market for innovation, and hold plans accountable to high performance through periodic re-bidding. State benchmarks show that 85% of bids are competitive and result in awards to two-thirds of bidders on average, indicating that procurements are successful at creating competition for services. Additionally, the majority (over 70%) of the 31 procurements profiled since 2015 were re-procurements, suggesting that states use re-bids to test the market and hold plans accountable for maintaining high performance. Conversely, NYS has no record of decertifying any plans.

Lastly, procurement allows states to evaluate plans more holistically and on a broader range of factors, including both past and future potential performance and areas that are less able to be quantified, such as approach to whole-person care or health equity. Procurement also allows states to prioritize criteria through weighting the scoring rubric. For example, in some states, questions related to plans' approach to social determinants of health constituted 25% of total available points in the procurement.

Optimizing the state's model contract is another powerful lever to reform the MMC market. NYS can improve requirements for quality, network adequacy, and enforcement provisions in its model contract. Examples of changes to the model contract include stronger quality incentives through a capitation withhold, enhanced network adequacy standards for BH and MLTC that take a member view in-line with expected CMS guidance, and clarity in public health law on penalties DOH can issue for contract violations.

The state should also work to enhance its active contract management (ACM) approach to hold plans accountable to these new requirements and become more proactive in its engagement and use of data with MCOs to advance program goals. However, doing so is challenging, given the high number of plans in the market today and current staffing resources within DOH.

By continuing to be bold and innovative in its Medicaid Program, NYS stands to enhance member and provider experience, reduce cost growth, and—most important—improve outcomes and access for New York's Medicaid members. Procurement can be a powerful tool to help achieve these objectives.

2 SUMMARY OF FINDINGS

Report Context and Introduction

This report, commissioned by the NYS Legislature, is structured as follows:

- The report begins with an overview of the current Medicaid Managed Care (MMC) offerings in NYS (Section 3)
- Next, the report provides additional background on MMC program design and how states select and oversee Managed Care Organizations (MCOs) (Section 4).
- The report next presents methodology (Section 5), including data sources and peer states utilized throughout the report, with further detail on analytical approaches in the appendix.
- The report proceeds to summarize findings of the current state and challenges for the three largest lines of business currently in place in the NYS MMC market: Managed Long-Term Care (MLTC) (Section 6), Mainstream (Section 7), and Health and Recovery Plans (HARP) (Section 8).
- The report summarizes NYS's approach to person-centered care across the lines of business (Section 9).
- Finally, the report shifts to evaluate three state levers in MCO management: selecting plans either through certification or procurement (Sections 10 and 11), optimizing the model contract (Section 12), and enforcing the model contract through ongoing oversight of MCO performance (Section 12). These three levers must work in concert to address MMC challenges.

This report addresses all requirements stipulated in the legislative text. The table below indicates the corresponding report section(s) in which each legislative requirement is covered:

Legislative Text	Section of Report
A market assessment of the MCOs offering products in each market, including the appropriate number of MCOs needed in each region to address member needs.	Section 6 (MLTC), Section 7 (Mainstream), Section 8 (HARP)
Analysis of areas of potential improvements or challenges as they relate to health care access, delivery, outcomes, administrative costs, efficiencies, and oversight that may result from competitive procurement.	Section 6 (MLTC), Sections 7–9 (Mainstream and HARP)
The current approach for addressing person-centered care for people with behavioral health needs enrolled with Medicaid managed care plans, including but not limited to special-needs MCOs authorized to offer HARPs and the integration of those benefits with Mainstream Medicaid Managed Care (MMMC).	Section 9
Procurement scenario impact on: • Cost savings • Provider network access • Managed care enrollee service disruptions • Providers that contract or are affiliated with Medicaid MCOs	Section 11
An evaluation of new performance standards or requirements that could be imposed upon Medicaid MCOs that participate in the managed care program pursuant to a contract with the Department of Health.	Section 12

An assessment of current mechanisms for enforcement of performance requirements, including but not limited to oversight of Medicaid MCOs and penalties.	Section 12

Before this summary explores report findings, a few methodological notes, which are further described in Section 5:

- Under federal law, states may experiment with their MMC programs, so no Medicaid programs across the country are exactly alike. In addition, not every state offers an MLTC or HARP product equivalent to those of NYS. This limits some direct comparisons, as noted throughout the report.
- Data availability varies depending on the state, region, line of business, or product. The report uses cross-state benchmarks wherever possible and calls out limitations of comparisons when appropriate. For certain analyses benchmarking NYS performance based on publicly available data, this report uses a set of peer states that vary depending on the line of business. These peer states are detailed in Section 5.
- As mergers and changes are ongoing in the market, this report counts plans based on their enrollment as of July 2022, regardless of their ownership structure as of the report's release.

The purpose of the executive summary is to provide a broad outline of the findings of the report with select, impactful data points. Complete data and findings supporting these conclusions is available throughout the report. Please note that Sections 3 through 5 are not summarized below, as their purpose is to set the background and explain methodology.

Summary of Section 6: Managed Long-Term Care (MLTC)

Background

NYS offers two main products within MLTC: Managed Long-Term Care Partial Capitation (MLTCP) and Medicaid Advantage Plus (MAP). MLTCP covers the vast majority (94%) of MLTC members.

MLTC programs are highly variable across states. Populations and services covered, member choice, plan geography, and participation in Medicare dual-eligible programs often differ, resulting in many nuanced models.

For its MLTCP product, NYS has made three core design choices: 1) providing long-term care benefits only, rather than including medical benefits; 2) excluding long-term nursing facility stays of more than 90 days; and 3) not mandating integration with Medicare. In contrast, other states—such as Michigan, New Jersey, Illinois, and Ohio—have service packages that include physical and behavioral health, along with long-term care. Still other states—California and Pennsylvania—have MLTC programs that separate long-term care from physical and behavioral health but include nursing facility stays.

MAP is a federally aligned Medicare dual special-needs plan (D-SNP) for dual-eligible members. Medicare-aligned products are more standardized nationally, as they must follow a set of federal rules; accordingly, NYS has made fewer independent design choices with MAP than it has for MLTCP. Unlike MTLCP, MAP provides both physical and behavioral long-term care, and the Medicaid product is fully integrated with Medicare. Many states have MAP equivalents.

Key Findings

NYS's MLTC program has 25 MCOs. NYS has more plans than its peer states do, and many of those plans have low enrollment (fewer than 1,000 members) per plan.

- In NYC Metro, members can choose from 13 plans on average. This is more than double the next benchmarked state, which offers members six plans.
- Outside NYC, members choose from three to four plans. In contrast, in benchmark states, members choose from two to three plans (i.e., one plan fewer). Outside NYC, enrollment per plan is lower. This reflects the low number of MLTC members outside NYC, as roughly 90% of MLTC enrollment is concentrated in NYC Metro.

The presence of so many plans in the MLTC market, and the existence of low-enrollment plans, contributes to several challenges:

- Plans with low enrollment have 14% higher per-member administrative costs than those with high enrollment. Low-enrollment plans are also less profitable, less likely to offer aligned Medicare products, and more likely to be rated one star (lowest quality) by the state. As a result, they have 25% higher complaint rates on average and are losing enrollment from members choosing to change plans.
- Having so many plans in the MLTC market increases provider contracting and billing burden. The large number of plans also stretches state resources for contracting and oversight.

The MLTC market faces other challenges beyond market composition.

- Quality issues and gaps in quality measurement:
    - Based on NYS's Consumer Guide plan ratings, members lack high-quality MLTC plan choices Upstate. There are no five-star plans and a greater share of one-star plans Upstate.
    - MLTC Partial varied widely on quality metrics. A review of the state's 2021 External Quality Review (EQR) report showed that 30-day readmission rates ranged from 7% to 24% (a spread of over 3x) and potentially avoidable hospitalizations rate ranged from 0.02 to 5.38 (a spread of ~270x).
    - Furthermore, MLTC quality measures are out-of-date and not consistent with national standards. These issues hamper the state's ability to benchmark performance to other states and hold plans accountable for improving quality. NYS's Consumer Guide plan-rating system for MLTC is a homegrown, state-specific solution. Additionally, the state paused the requirement for annual reassessments using the New York Uniform Assessment System of Community Health Assessment (UAS-NY CHA) from March 2020 through July 2021 due to the COVID-19 pandemic. As a result, Consumer Guide ratings have not been updated since 2019 and the quality metrics section of the 2021 MLTC EQR report was unable to be completed.
- Limited alignment with Medicare: The vast majority of MLTC members were dual-eligible for Medicare in 2019 (85–90%). However, based on 2021 data, most dual-eligible MLTC members (~84%) would require a plan or carrier change to receive integrated care with Medicare. Thirteen of 25 MLTCP plans do not offer Medicare Advantage–aligned plans.
- Provider access:
    - While NYS ranks first in the nation in home health and personal care aides, it ranks 42nd in registered nurses and 39th in nursing assistants. This gap in providers may impede members' ability to receive higher-acuity care at home.
    - NYS currently has over 600 Licensed Home Care Services Agencies (LHCSAs). The state has tried to decrease the fragmentation of the LHCSA market by capping the number

each plan can contract with. Despite the proliferation of LHCSAs in the state, it is difficult to evaluate true accessibility of these services for members. There are three key limitations in NYS's existing network adequacy standards for LHCSAs. First, current standards look only at the number of contracted LHCSAs rather than accounting for the number of actual providers (i.e., personal care aides providing care in the home). Second, having an LHCSA under contract does not necessarily mean that it is providing services to Medicaid patients; 11% of MLTCP and 36% of MAP LHCSAs did not bill for a single Medicaid patient in the past year. Third, standards do not account for the time and distance between the LHCSA workforce and members, which can limit accessibility.

Conclusions

Overall, the MLTC market is fragmented, with too many market players and small plans. There is significant room for improvement in offering integrated Medicare and Medicaid plans to members, improving plan quality (especially Upstate), enhancing access and quality standards, and simplifying administrative infrastructure for providers, plans, and the state. Since many of these challenges are tied to the number of plans offered overall and the number of low-enrollment plans in the market, giving the state a mechanism to select the optimal number of plans through a procurement is a potential key lever toward improvement.

Summary of Section 7: Mainstream

Background

Mainstream is NYS's largest line of business, accounting for over 90% of total MMC enrollees. Mainstream is the general MMC product for populations who do not qualify for a specialized product. NYS has structured its Mainstream program to provide integrated physical and behavioral health coverage, meaning physical and behavioral health benefits are covered by the same MCO.

Key Findings

NYS has 12 Mainstream MCOs, more than any benchmarked peer except California. Given large Mainstream Medicaid enrollment in NYS, enrollment per plan is relatively in line with peers.

- In NYC Metro, members can choose from seven plans on average, versus two to nine plans in peer regions (with most peers having five or fewer plans). Plan enrollment in NYC Metro is high, given large overall Medicaid membership in the region; only one peer metro area has higher average enrollment per plan than NYC.
- Outside NYC, plan choice is in line with peers, with three to four plans available to members on average, versus two to six for peers. Upstate plan enrollment is also comparable to peers, falling roughly in the middle of the benchmark set.

The Mainstream market performs well on average relative to peers in several areas, namely quality and administrative cost.

- Quality: On a set of 13 benchmarked quality measures, NYS outperforms the national 50th percentile on 10 measures, the national 75th percentile on seven measures, and the national 90th percentile on one measure. When narrowing the comparison set to only a smaller group of peers, NYS also outperforms all seven peer states on this set of measures.

- Administrative cost: NYS's average administrative loss ratio (ALR) of 8.2%, a measure of the amount of revenue spent on administrative versus medical costs by an insurance plan, is below the national average (11.2%) and peers (10–16%).

However, opportunities for improvement remain in three main areas:

- Market composition: The Mainstream market has 12 plans, and several are relatively small (seven plans have less than $1 billion in annual Mainstream revenue, which this report considers to be a small Mainstream plan). Therefore, while on average the number of members per plan is similar to peers, many of the same market composition–related pain points found in MLTC are likewise observed in Mainstream:
    - Compared to large plans, small plans have 28% higher per-member administrative costs, are less profitable, and have 50% higher complaints per member on average.
    - Having a large number of plans in the market increases provider contracting and billing burden and stretches state oversight resources.
- Presence of low-performing plans: While NYS performs well on average on physical health quality and administrative costs, as noted above, these averages smooth differences in performance among plans. For example, in 2019, plans spent between 6.4% and 16.7% of their revenue on administration, a 2.6x difference. That low-performing plans endure in the market signals ample opportunity for NYS to institute market-leading performance standards.
- Behavioral health (BH): This report finds a range of challenges with BH within MMC. Access is a key concern. NYS faces a greater shortage of psychiatrists than the U.S. average. Additionally, NYS's standards for BH services are structured differently than most states and may not be sufficient to ensure access to in-network services, though plans are required to arrange for out-of-network services if in-network services are not available. Regardless of whether existing standards are sufficient, some plans are non-compliant with existing standards, and a significant portion of contracted providers are not actively treating Medicaid patients. In the face of these challenges, MCOs are still not spending all their allotted premiums for BH services and have not materially engaged in state-driven efforts to improve access or quality of care to date.
    - **Psychiatrist shortages:** While there is a national shortage of psychiatrists, NYS is found to face greater challenges. A 2022 KFF study found that NYS meets approximately 19% of its need for psychiatrists compared to the U.S. average of ~28%, ranking 41st in the nation (based on a ratio of 30,000 providers to 1). Meanwhile, 88% of counties fail to meet NYS's state-specific adequacy standard for psychiatrists (~6,500 providers to 1). In comparison, all counties are compliant with NYS's member-to-provider ratios for contracted Primary Care Physicians.
    - **BH service network deficiencies:** Beyond psychiatrists, analysis from the Office of Mental Health (OMH) indicates that 14% of BH service networks are deficient across plans. Deficient is defined as any instance of a plan failing to meet one of the 17 BH network contracting standards. NYS generally requires that Mainstream and HARP MCOs have two BH service providers per county in urban areas and two per Regional Planning Consortium (RPC) region in rural areas. Compliance with NYS's standards may therefore underestimate access challenges members face, particularly in rural counties. For example, based on our independent analysis, a member in a rural county may have to drive up to three hours to reach the nearest contracted provider in the RPC region. In such instances, plans should arrange for transportation to a closer out-of-network provider, with the transportation paid for by Medicaid. Although access challenges are primarily caused by workforce shortages, there is still an opportunity to increase network adequacy standards in rural areas. If current standards were raised to require

rural counties to have two BH service providers per county rather than RPC region, our analysis finds that 24% of networks would be deficient, an increase of 10 percentage points from OMH's analysis. A comparison of NYS's BH network adequacy standards to other states' standards can be found in Section 12 of the report.

- **Inactive providers:** Access is further constrained by the fact that having in-network providers is not a guarantee of member access. Based on an analysis of 2021–2022 NYS claims data, nearly half (43%) of BH providers (including psychiatrists, psychologists, licensed social workers, and licensed behavioral analysts) listed in plan directories did not bill for any Medicaid members. The methodology for this analysis is detailed in the appendix.
- **MCO BH parity violations:** The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law designed to ensure fair and adequate access to BH services. NYS MCOs were issued 95 citations for noncompliance from 2018 to 2020. A 2022 survey of MCO documents found that several MCOs repeatedly failed to demonstrate compliance, with most violations due to reporting problems, although several actual parity violations were also found.
- **MCO underspending on BH:** Even with insufficient provider networks, MCOs are not spending all their allotted premiums for BH services, with over $220 million remitted from plans back to the state from 2017 to 2020.
- **Inappropriate claims denials for BH specialty services:** OMH reviews of BH claims reports submitted by MCOs have found high levels of inappropriate claims denials for BH specialty services. Based on MCO-reported claims data from December 2017 to May 2018, OMH estimates there were $39 million worth of claims denials for BH services above an administrative denial threshold set by OMH. The estimated dollar value reprocessed and paid by MCOs for these claims in response to NYS action was $11.6 million. While additional funds were subsequently recovered, inappropriate claims denials and delayed payments keep funds out of the BH system, impair the provider experience, and strain state oversight resources. DOH and OMH issued citations and conducted targeted surveys in response to this issue, significantly reducing inappropriate claims denials. Similar root-cause analysis of claims data from April 2021 through September 2021 found an estimated $11.5 million in claims denials above the set threshold—about a 60% reduction.
- **Limited MCO innovation and engagement in improvement efforts:** MCOs have shown little innovation to improve upon workforce challenges and increase access. There have been no applications for in-lieu-of services, and despite network requirements, managed care has relied on additional government funding to bring inpatient psychiatric beds online. In some cases, OMH has also struggled to entice MCO participation in quality-improvement initiatives.

Conclusions

Several of the NYS Mainstream market's many plans are low-performing, indicating that increasing competition or selecting the best plans could improve the market.

Choosing the top-performing plans may not be sufficient to fully address behavioral health challenges, however. Further intervention is likely needed, given that access is deficient across the market and there is a national shortage of behavioral health providers. BH funding has been returned from plans to the

state, demonstrating that plans have not used all available financial resources to improve BH care delivery.

NYS can address these challenges by improving product design, increasing competition among plans, and raising and enforcing contract standards.

Summary of Section 8: Health and Recovery Plans (HARP)

Background

NYS is one of 30 states (of 41 with MMC) that carve behavioral health (BH) into MMC. However, many unique models exist, with variation in which populations and services are covered. NYS introduced the HARP program in 2015 as part of a broader BH transition from fee-for-service to managed care. The goal was to address rising rates of mental illness and substance abuse, increasingly poor outcomes in measures such as readmission rates for those with severe BH needs, growing costs of fee-for-service health care, and an escalating need for more integrated and comprehensive care. To meet this goal, decision-makers wanted a specific managed care product created for members with a mental illness or substance use disorder (SUD).

HARP plans provide Medicaid coverage and specialized services for adults with serious mental illness (SMI) or SUD. In addition, HARP plans provide the same physical and behavioral health coverage as Mainstream plans, and they offer enhanced care management and expanded benefits, including BH home- and community-based services (HCBS) and community-oriented recovery and empowerment (CORE) services. HARPs also have requirements around staffing qualifications for adequate provision of care.

Eleven MCOs offer HARP and Mainstream plans; the 12th and final Mainstream MCO is expected to add HARP enrollment in the coming year. The alignment of Mainstream and HARP MCOs was an intentional design choice by the state to ensure continuity of care and seamless transitions across the two products as members' needs evolve. Mainstream members who qualify for HARP are passively enrolled into their same MCO's HARP plan.

Key Findings

The HARP model has successfully enrolled the majority (85%) of eligible members with high-acuity BH needs into specialty HARP plans, as intended by its product design. Despite this success in enrolling eligible members, HARP has not yet improved BH provider access, utilization, or outcomes.

- <u>BH provider access gaps:</u> Given the >99% overlap in the provider networks between Mainstream and HARP plans, the provider access gaps discussed in Mainstream also plague HARP. The impact of these gaps is magnified in HARP since it is designed to serve high-acuity members with SMI/SUD.
- <u>Low utilization of specialized services and care management:</u> In theory, access to Health Homes and specialized HCBS and CORE services is meant to differentiate the HARP service offering from Mainstream. However, only 21% of HARP members are enrolled in a Health Home and only 3% of members used HCBS or CORE services in the past year.

- Limited outcomes improvement: HARP program implementation has not resulted in meaningful improvement of quality-of-care measures related to mental health services. Between 2015/2016 and 2020, HARPs demonstrated no change in performance on key measures such as seven- and 30-day follow-up after a hospitalization or ED visit and potentially preventable readmissions for mental health.

These challenges are not isolated, but rather exist within a broader context of pervasive issues in BH care delivery across the nation, both within and outside Medicaid managed care. In recent years, these issues have been further compounded by the COVID-19 pandemic, ongoing BH workforce shortages, and increasing demand. For example, a recent study on Oregon published in *Health Affairs* found that Oregon is one of eight states with a Medicaid reimbursement rate that is on par or greater than Medicare for mental health services, but the state consistently ranks among the worst states for access to mental health services, due to high demand, workforce shortages, and provider administrative burden.

However, NYS has made certain product decisions for HARP that have contributed to the program's shortcomings:

- Undifferentiated MCOs in HARP model: NYS designed HARP to ensure continuity of care and seamless transitions with Mainstream MCOs. As a result, members can choose from a large number of HARP plans. An alternative approach would have been to use procurement to select the best MCO to specialize in BH, offering the highest quality experience for BH members with the largest BH provider network. While other states have likewise created a specialty BH MMC product (e.g., Ohio, Arizona, Pennsylvania), this report has not identified another state that did not constrain the number of participating MCOs. For example, Ohio ran a procurement to select a single high-quality plan for its specialty youth BH product.
- Overlapping roles and responsibilities across stakeholders: Several disparate stakeholders (MCOs, Health Homes, care-management agencies, providers) have overlapping roles and responsibilities, particularly for care management. This blurs the lines of accountability and results in a duplicative care management experience for members. Care managers play a pivotal role in directing members with BH needs to care; the Substance Abuse and Mental Health Services Administration has found that one third of adults aged 18 or older in the U.S. who reported having a mental illness and an unmet need for services indicated that they did not receive care because they did not know where to go for services. Overlapping care management roles in NYS's HARP program may be a contributor to HARP members' low utilization of HCBS/CORE services by potentially causing confusion or impeding access for individuals with SMI/SUD. These issues compound with challenges individuals with SMI/SUD face, including stigmatization, barriers to care, intricate treatment regimens, and challenging social needs. NYS can consider revisiting roles and responsibilities in this model in a person-centered manner based on who is best positioned and trusted to engage patients.
- Ineffective incentives in the Health Home model: Health Homes are more incentivized to engage mild to moderate members over high-acuity members. This is because reimbursement is based on continued engagement with members, and high-acuity members can be more difficult to engage consistently. The Health Home Plus model, with higher reimbursement rates for those with the most severe BH needs, was introduced to address this shortfall. Uptake of the Health Home Plus model has been limited. NYS can look for ways to better scale the Health Home Plus model and track utilization more actively.

Conclusions

NYS is an outlier in creating a specialty BH product that is distinct from its Mainstream product but has the same set of MCOs and same care management model. MCOs face similar issues in both the HARP and Mainstream markets. The current care management model is impaired by blurred lines of accountability across entities and flawed incentives. A procurement—whether for HARP only or for Mainstream and HARP jointly—could help improve BH access, utilization, and outcomes by enabling NYS to select the plans that are best equipped to provide integrated physical and behavioral health for members with high-acuity BH needs. NYS can also consider redesigning its care management model. Improving BH broadly is explored further in the next section.

Summary of Section 9: NYS's Approach to Person-Centered Care

Background

In addition to specific analysis of the lines of business in the managed care market, the legislative text asks for this report to consider "The current approach for addressing person-centered care for people with behavioral health needs enrolled with Medicaid managed care plans."

The National Institutes of Health (NIH) defines whole-person care (i.e., person-centered care) as "looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease. It means helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of treating a specific disease, whole-person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan."

Person-centered care is built on three interdependent pillars: care model, payment model, and governance model. Each must be organized around the totality of an individual's needs, spanning physical health, behavioral health (BH), and social needs. This is an area of continued exploration and experimentation across state Medicaid programs, with all striving to shift the current delivery system to one that can meet the ideal state defined by the NIH, among others.

Key Findings

In evaluating NYS's current approach to person-centered care for members with BH needs, care model and payment model are assessed together, given their tight interplay.

<u>Care model and payment model:</u> NYS has three key vehicles for delivering person-centered care for members with BH needs: the patient-centered medical home (PCMH) primary care model, the Health Home model, and the Certified Community Behavioral Health Clinic (CCBHC) model. All are national models that many states have adopted. As of 2019, 30 states reported having PCMHs in place. Nineteen states were operating some form of Medicaid Health Homes as of 2022. NYS was one of eight states to implement the CCBHC model in a 2017 demonstration program, and now there are more than 500 CCBHCs operating in 46 states.

PCMH provides accessible, coordinated, and comprehensive primary care with a commitment to quality improvement. It is a model used nationally to make primary care more patient-centered and to move

toward greater behavioral health integration. While PCMH practices do not necessarily have fully integrated behavioral health, they must adhere to core principles on care coordination, care management, care transitions, and quality reporting, all of which are critical to BH. NYS is often considered a leader in PCMH, with 20% of all PCMH-recognized practices nationally located in the state. Moreover, the influential Center for Health Care Strategies highlights NYS's model as one of three state exemplars that go beyond typical standards for PCMH.

The Health Home model is designed for high-risk members, such as those with multiple chronic conditions and/or BH needs. Health Homes are a partnership of care-management agencies and community organizations that promote access to and coordination of care. Health Homes assign each member a care manager who is responsible for developing a care plan and helping members stick to it by providing additional support and services. Care managers, Health Homes, MCOs, and providers must work together to conduct person-centered service planning (PCSP) according to NYS DOH guidelines required by the HCBS final rule. HARP members automatically qualify for Health Homes, while Mainstream members qualify if they have either an SMI or two chronic conditions.

CCBHCs deliver a blend of mental health, substance use disorder, and physical health treatment services. They are required to provide crisis mental health services, screening and assessments, patient-centered treatment planning, targeted case management, psychiatric rehabilitation services, and peer support and counseling services, among other services. The goals of the CCBHC model include improving access to treatment, reducing preventable admissions, building better relationships between hospitals and community health care providers, and increasing payments to community providers working in underserved areas. NYS has carved out CCBHCs from MMC, so they bill FFS to the state and NYS pays a single daily Prospective Payment System rate for services provided. Although CCBHC services are carved out, MCOs can still access client level CCBHC quality reporting data.

Governance model: From a governance and program-design perspective, NYS has pursued person-centered care through the integration of physical and behavioral health coverage (i.e., provided by the same MCO) within Mainstream and HARP. Integrated coverage is considered best practice because physical and behavioral health issues are often interrelated. For example, 92% of health care costs for those with a BH condition come from spending on physical health needs. Integrating coverage can enable tighter care coordination and aligned incentives across the care continuum; it has been found to improve outcomes, access, and costs while also delivering a more patient-centered experience, such as by reducing the stigma of seeking BH care.

NYS is deploying the whole-person care models and best practices often considered by states, but the current approach suffers from three main challenges:

Lack of more advanced provider integration: Despite integrated coverage of physical and behavioral health benefits, gaps persist in provider integration. While appropriate structures and programs have been put in place, interviews suggest they are not fully utilized. For example, though physical and behavioral health care teams are meant to be integrated, only 50% of care-management records reviewed for HARP members list any physical health conditions.

Low utilization of integrated programs: Many members, despite being eligible, are not using the services designed to deliver person-centered care. While 68% of members are affiliated with a PCMH-recognized PCP, case record reviews show that 53% of high-need BH members had not seen their assigned PCPs in the prior 12 months. As discussed in the HARP section, Health Homes are likewise challenged by a lack

of utilization, with fewer than 25% of HARP members enrolled despite members automatically qualifying.

Absence of a unified state approach: PCMH, Health Homes, and CCBHCs are treated as separate initiatives and promoted and used in different ways for those with BH needs, instead of being part of a holistic state approach to whole-person care. NYS can consider where the PCMH, Health Home, and CCBHC models intersect and how these programs optimally fit together to deliver person-centered care, taking a population-segment approach. NYS can also look to learn from other states that have taken holistic approaches. For example, from 2016 to 2021, California conducted 25 regionally focused pilots for whole-person care that provided comprehensive services for 250,000 high-need members through a localized, community approach. County health departments or public hospitals were responsible for driving collaboration with community organizations and MCOs. Initial results from the state showed $400 per member per month (PMPM) cost reduction, with 130 fewer ED visits and 45 fewer hospitalizations per 1,000 beneficiaries. OHIP has proposed a similar regional coordination approach in the pending NYS 1115 waiver request. As more results are released from California's model, NYS can apply learnings to its own approach.

Conclusions

While NYS has integrated physical and behavioral health coverage by design, in practice, provider integration and utilization of integrated programs are limited due to gaps in care coordination. Furthermore, NYS has pursued disparate whole-person care initiatives, resulting in redundancies. NYS can look toward defining a holistic person-centered care approach and using procurement, contract standards, and contract enforcement to select and manage MCOs in support of that vision.

Summary of Section 10: Certification and Procurement

Background

With its "any willing plan" certification model, NYS is one of six states that do not utilize procurement to select MCOs. NYS uses procurement to award contracts to provide many other privatized services. The remaining 35 of the 41 states with MMC use procurement.

Key Findings

Given that there are few states that are not already procuring MCOs, there are no recent examples of a state moving from certification to procurement to analyze the potential outcomes of such a shift. However, benchmarking and case studies of procurement show that states use procurement to directly impact their health priorities.

Based on a review of other states' most recent MMC procurements since 2015, which includes 31 completed procurements across 26 states, procurement is especially effective in driving program goals for four key reasons. Namely, procurement allows states to set priorities and require clear MCO responses; set an optimal number of MCOs; drive competition, innovation, and accountability; and score plans more holistically through both qualitative and quantitative measures.

Set priorities and require clear MCO responses: RFPs serve as clear statements of the state's priorities. Furthermore, RFPs require MCOs to respond directly to those priorities and give NYS the opportunity to

see what is out there—a best practice across government procurement when the vision is clear but the solution is not. Publicly stated goals are kept broad, but technical criteria within RFPs are tailored to state priorities and commonly include questions on quality management, provider access, and care coordination.

Three examples demonstrate how states use procurement to execute MMC program goals. First, Virginia's Secretary of Health and Human Resources framed the state's $14 billion procurement planned for 2024 as transformational to advance program goals including driving innovation and strengthening quality and accountability in its managed care program.

Second, expert interviews on California's 2020–2022 procurement reveal that the state considered their managed care procurement and their signature CalAIM whole-person care policy linked; California used procurement to ensure they had the right market players and contract requirements to implement the enhanced behavioral health and social-need services that are the cornerstones of CalAIM. Procurement can also serve as an opportunity to engage stakeholders in defining strategic priorities.

Lastly, Michigan recently engaged over 10,000 residents to help develop five strategic pillars for its upcoming re-procurement. 85% of the respondents were from Medicaid members or family members, and the remaining 15% were other health care stakeholders, including plans and providers. The five pillars are focused on delivering coordinated whole-person care, supporting kids, promoting health equity, driving innovation and operational excellence, and engaging members and communities.

Set an optimal number of MCOs: States may publicly communicate a target range or number of MCOs to be awarded contracts either statewide or per region. For example, of five procurements explored in detailed case studies, three—Indiana MLTSS, Ohio Mainstream, and Pennsylvania MLTSS—communicated an explicit target number of MCOs in their procurements, ranging from two to five MCOs per region or statewide. They largely stuck to these targets, with each state awarding three to seven MCO contracts. Looking more broadly at the 31 procurements profiled since 2015, a range of one to 11 MCOs were awarded contracts. The majority (~75%) of states awarded between three and six contracts. No state awarded bids to as many MCOs as NYS currently has in the Mainstream market (12). Certification, on the other hand, does not allow DOH to directly set a fixed number of plans with which to contract to achieve the plan size that could help drive improvements in cost, quality, member and provider experience, and state oversight.

Drive competition, innovation, and accountability: Procurement encourages bidders to strive to be the best, while certification merely sets a minimum performance floor. 85% of procurements profiled were competitive, with states selecting two-thirds of bidders on average, indicating that procurement enables states to select from the top performers. Furthermore, re-procurement allows the state to routinely test the market for new ideas, reset contract standards, and provide a clear check on low performance if plans want to remain in the market through periodic re-bidding. The majority (over 70%) of the procurements profiled since 2015 were re-procurements. Certification does not regularly prompt competition, nor does it push the market toward innovative solutions as explicitly, therefore limiting the state's ability to drive best-in-class performance and hold underperforming plans accountable. Additionally, DOH has no recent record of decertifying any plan (which would be analogous to a re-bid).

Score qualitatively and quantitatively: Procurement allows DOH, through a scoring rubric, to evaluate plans more holistically. Certification requires everything to be "all or nothing," creating many must-haves with no relative prioritization. An RFP allows evaluation on a broader range of factors, including

both past and future potential performance, and those areas that are less able to be quantified, such as approach to whole-person care, tackling disparities, or striving for health equity. States that have begun prioritizing social determinants of health (SDOH) and/or community reinvestment strategies in their Medicaid programs are able to specifically tie such goals to requirements in an RFP; in some states, SDOH-related questions constituted 25% of total available points in the procurement.

Nevertheless, procurement—or decertification—is not without risks. Two considerations in any procurement are MCO pushback and member disruption. However, states have proven tactics to help manage these issues. First, appeals and litigation from losing bidders occur in nearly every procurement profiled. The size of MCO contracts today creates a strong incentive for any procurement losers to file unfounded appeals and try their hand in court. But, having sufficient internal resources to manage the procurement effort, engaging with stakeholders before the bid, having a clear, transparent procurement process, and documenting that the state is following established processes helps win appeals. For example, Ohio and Indiana led extensive stakeholder engagement prior to RFP release. One losing bidder in Ohio protested, but the state's decision was upheld in court; to date, no appeals have been filed in Indiana. Pennsylvania awards were upheld after four appeals.

Second, given that most bids are competitive, it is common for members to need to change plans. About 20% to 30% of members in benchmarked states need to change plans following a procurement, based on available data. Members who need to switch plans may benefit if the state selects top-performing plans in a procurement, as they are likely to be moved to higher-performing plans. Such transitions would likely occur in a decertification as well. States can support smooth transitions by enacting contract requirements to require continuity of care while terminated plans are phased out and by ensuring state operations, data, and technology systems are robust enough to support member transitions. Despite these risks, states are generally successful in completing their procurements. Canceled procurements are rare, with only three known cancellations since 2015 versus 31 completed.

Specific to the challenges observed in the MLTC market, procurement could allow DOH to award the optimal overall number of plans to address market fragmentation and select for plans that have a proven ability to report standardized quality and access measures according to federal guidance, administer a large health plan, and control costs. Procurement could also enable DOH to prompt the market for innovation to support the state's goals regarding dual-eligible integration with Medicare and helping members to age in place as part of the forthcoming Master Plan on Aging.

For the challenges found in the Mainstream and HARP markets, procurement could allow DOH to make wholesale changes to the provision of BH services. Procurement allows for a broader discussion of behavioral health goals and how the managed care program can achieve those goals in product design; the flexibility of procurement is necessary to fully consider available product options. Further, in a procurement, the state could score bidders based on past performance and past deficiencies or findings, and/or ask specific RFP questions to understand the plan's approach to integration. Regular re-bidding in a procurement would serve as another enforcement mechanism of compliance with BH standards, such as quality, access, and parity. More broadly, a Mainstream procurement would allow the state to specifically test the market and innovate on its policy goals, including on integration of social determinants into managed care as part of the NYS Medicaid 1115 Demonstration Waiver amendment proposal, or a more specific focus on health equity and quality measures that targets disparity.

Conclusions

While NYS could address the challenges confronting the MMC market today by raising certification standards, procurement is likely to be more effective. Of the 41 states with MMC, 35 use procurement as a mechanism to communicate and advance their goals; set an optimal number of market players; regularly drive competition, innovation, and accountability; and score MCOs more holistically and with more nuance than certification allows. Procurement is a proven tool not only for those states' MMC programs, but also for NYS as it routinely uses procurement for other government contracting.

Summary of Section 11: Procurement Scenario Analysis

Background

The legislative text asks for the report to assess the potential impact of a procurement on cost savings, provider network access, managed care enrollee service disruptions, and impacts to providers that contract or are affiliated with Medicaid MCOs.

As described in Section 10, raising MCO standards through a procurement can help address challenges by allowing the state to directly contract with the right number of plans and use competition to determine the best plans to deliver services. To understand the potential range of impact from procurement, we modeled four scenarios aligned against potential state improvement goals across MLTC and Mainstream/HARP:

- Improved quality (MLTC and Mainstream/HARP)
- Administrative cost efficiency (MLTC and Mainstream/HARP)
- Increased alignment with Medicare (MLTC only)
- Enhanced access to BH services (Mainstream/HARP)

These scenarios are not exhaustive of all state goals for each line of business, but they were crafted based on two principles. First, these are among the top potential priorities given the challenges and opportunities for improvement highlighted in this report. Second, these measures have readily available associated quantifiable metrics to use as criteria, whereas other state goals that are important (e.g., SDOH, equity, and provider experience) do not. The selected scenarios leverage the most authoritative available metrics that are consistent year-to-year, robust, and measurable by the state based on reported data.

Each scenario eliminated plans that did not meet the new requirements based on historical performance, and we analyzed the impact to members, providers, access, and state costs. Modeling the impact of the scenarios has two key limitations. First, no plan or market adaptation is modeled. In the scenario analysis, plans' prior performance determines their future performance, while in reality, the market is likely to adapt even prior to a procurement. For example, the state announcing a planned procurement may prompt M&A activity in the market as plans anticipate being unable to win a bid independently. Furthermore, plans' performance may change over time as the market evolves. For example, if the procurement selects certain high-performing plans, that does not necessarily guarantee the plans will maintain their strong performance throughout the contract period. Effective contract standards and active contract management are still required to drive plan performance toward state goals. Second, scenarios are defined by binary criteria, whereas in a procurement, the state will evaluate and score plans more holistically on multiple quantitative and qualitative metrics.

Key Findings

Impact from a procurement is highly dependent on the specific criteria used. Given the limitations described above, actual member and provider impact may be lower (or higher), and improvements to cost, quality, and access may be greater (or less) than modeled.

In these illustrative scenarios, procurement could drive substantial improvements for the member and the state, including:

- Placing every member in a high-quality plan (MLTC and Mainstream).
- Generating up to $300 million in annual administrative cost savings (combined across MLTC and Mainstream), without accounting for potential additional administrative cost savings through economies of scale as remaining plans expand membership
- Achieving full alignment between long-term care and physical health benefits for dual-eligible members (MLTC).
- Improving behavioral health access moderately for members (Mainstream/HARP) by increasing average plan compliance with the state's mandated minimums for BH services.
- Reducing market fragmentation (MLTC and Mainstream), leaving 11 to 18 plans in MLTC (a 25%–50% reduction) and three to seven plans in Mainstream/HARP (bringing Mainstream/HARP in line with benchmarks).

If NYS procures, it should implement mitigation strategies for two foreseeable near-term risks:

Risk 1: Any change to meaningfully raise standards on MCO performance will cause members and providers to switch to or re-contract with higher-performing plans.

- The projected impact of procuring MLTC is up to 25% of members changing plans. The projected impact to members if Mainstream/HARP is procured is higher (up to 60% changing plans) in some scenarios.
- Up to 20% of MLTC providers and up to 30% of Mainstream/HARP providers will have all their contracted plans eliminated and will need to re-contract based on scenarios modeled.

However, this risk can be mitigated successfully. Impact to members and providers is common in peer procurements and is manageable by the state. Furthermore, it would likely be smaller than modeled in this analysis and is in the long-term interest of the members and providers:

- Peers see up to 30% of members change plans during a procurement.
- NYS already has contractual provisions to mitigate member disruption in the event of plan termination.
- Upon the state's announcement of a procurement system, the market is likely to respond to improve performance (e.g., through changing processes, M&A, etc.), increasing the percentage of members and providers whose plans survive procurement.
- In a market with fewer plans that are held to higher standards, members and providers can benefit in the long-term through enhanced member/provider experience, higher quality, better health outcomes, and lower costs.

Risk 2: In both MLTC and Mainstream/HARP, many upstate members are outside the service area of the highest-performing plans.

- If NYS eliminates low-performing plans, the state needs high-performing plans to offer services upstate. In crafting its RFP, the state could allow MCOs time to adapt to the new standards or

require high-performing plans winning a procurement to expand their service area to serve these upstate areas.

Conclusions

Procurement can improve cost savings, especially in Mainstream/HARP, as well as alignment of care in MLTC and quality of care in Mainstream/HARP and MLTC. Procurement can also modestly improve BH access in Mainstream/HARP if plans are selected based on performance on current network adequacy standards. These improvements are incremental to other benefits of market consolidation, including enhanced state oversight. Procurement also comes with risks: Members will move plans, providers will have to re-contract, and Upstate members may have few plans to choose from. However, risks to members and providers are routinely addressed by peer states, and plan choice can be protected by requiring bids in specific geographies (e.g., Upstate) to ensure high-performing plan coverage across the state. In a market with fewer plans that are held to higher standards, members and providers can ultimately benefit in the long-term through enhanced member/provider experience, higher quality, better health outcomes, and lower costs.

Summary of Section 12: Contract and Contract Management

Background

Contracts and contract management are critical levers for the state to deploy, building upon any decisions made about certification or procurement. While certification or procurement selects the players in the market, the contract and its management can ensure that MCOs live up to the standards or face consequences. States who use procurement often update their model contracts alongside the RFP to ensure that any promises made in an RFP are appropriately codified and become clear requirements. Expert interviews suggest states may need to procure in order to make significant contract changes that otherwise could be considered material and prohibited under state law.

There are two basic approaches to enhancing oversight of MCOs:

<u>One-time changes to contracts:</u> achieving state goals by including clear requirements, incentive arrangements, and enforcement mechanisms in contracts.

<u>Ongoing active contract management (ACM):</u> driving MCO performance and accountability across goals by enforcing contract provisions and implementing proactive strategies.

The NYS model contract, which all MCOs must sign with DOH, is based on public health law and regulations. Public health law includes the requirements that MCOs need to meet to be certified. Regulations—written and promulgated by DOH—outline the ongoing rules and processes of monitoring and enforcing legislation that MCOs must comply with to continue to be certified. The model contract provides additional details and greater specificity but ultimately refers to the statute and the regulation, where the actual requirements live.

NYS's contract management approach currently consists of the following mechanisms:

- Ongoing surveillance and quality review, including comprehensive operational surveys (COS) conducted every two years, targeted operational surveys (corrective, in response to findings from the COS), and focused and ongoing review activities.

- Monthly joint meetings with all MCOs covering MMC program updates, initiative specific updates, and guidance on policy and regulation.
- Citations and sanctions/penalties, available in statute and contract. If an MCO is found in violation, DOH first issues the MCO a statement of deficiency/findings and then a plan of correction, which the MCO can dispute. Performance is then monitored and assessed again through operational and focus surveys. If an MCO is found to repeat the same violation, then OHIP will move to enact sanctions in concert with the Division of Legal Affairs, such as financial penalties or plan enrollment penalties. While termination (decertification) is also a lever available to NYS, there is no recent record of NYS decertifying a plan.

Key Findings

These two approaches must be pursued together. The contract must set clear, meaningful, member-centric, and enforceable standards. ACM must be in place to ensure that standards are reached and to engender a data-driven culture of continuous improvement for both the state and its MCOs. Such an approach is difficult in NYS today due to the large number of overall plans and the current resources available to conduct contract management and oversight.

Section 12 takes a complete look at best practices in contracts and finds that the state has the greatest potential opportunity to change and increase contract standards in several areas.

Quality: While the state has a quality-incentive bonus program, it might benefit from moving certain MCOs to a quality withhold; this reserves part of the MCO payment until standards can be reached. For example, Arizona, Michigan, Oregon, Texas, and Washington withhold a portion of capitation payment that MCOs can earn back if quality thresholds of performance are met.

Provider access: Network adequacy standards—especially for LHCSAs and behavioral health—can be strengthened, particularly by incorporating new standards that create access from a member perspective, in line with new guidelines recently proposed by CMS. For example, in a survey of 39 states with Medicaid managed care, 28 had time and distance standards defined for mental/behavioral health, 14 had distinct standards for SUD treatment specifically, and seven had wait-time standards for BH providers.

Enforcement mechanisms and penalties: Regardless of current resources, the state's contract enforcement effectiveness is constrained by limited and unclear financial penalties and rules in public health law. Financial penalties are specified directly in public health law, which uses an inflexible $2,000 maximum fine per infraction instead of referring to damage clauses in the contract. If financial penalties are not proportional to the infraction, MCO incentives for compliance may be weakened. In contrast to NYS, California can adjust sanctions proportional to damages, ranging from $25,000 to over $400,000 per infraction. In 2022, California issued a record $55 million fee against its largest MCO for failing to provide adequate, timely care.

Clarity in public health law on potential damages and the process by which the state can assess penalties would reduce legal risk in this area and strengthen DOH's hand in pursuing clear penalties related to the above or other meaningful contract violations, such as BH parity. It would also speed up the process of enforcement by clarifying what constitutes a specific "violation" under the law or contract. Finally, statements of deficiencies and findings are not transparent to the public and could be more simply communicated to stakeholders.

To pursue ACM, the state should consider increasing the frequency of its performance reviews outside formal surveillance activities. In particular, NYS could launch monthly or quarterly data-driven MCO-specific meetings to transparently review progress on key measures. However, the state likely lacks the resources to perform such reviews, given the current number of vacant positions in the state divisions related to managed care contracting/oversight and the number of MCOs in the market.

Conclusions

States employ two levers to hold contractors to high standards: contract standards and active contract management. These levers are most effective when employed together and in support of goals being pursued through certification changes or a procurement. NYS can strengthen language on quality, access, and enforcement penalties. NYS can also pursue active contract management by increasing reviews of plans, improving use and transparency of data, and shortening the cycle between review and action. To have the capacity to employ these measures, the state will need to significantly augment its oversight staff and/or reduce the number of plans overseen.

3 OVERVIEW OF CURRENT MCO OFFERINGS IN NYS

MCOs cover approximately six million people in NYS (80%[1] of total Medicaid enrollees as of July 2022).

This report considers NYS's three largest lines of business that together comprise over 99% of total enrollment: Mainstream (92% of enrollees), Health and Recovery Plans (HARP, 3%), and Managed Long-Term Care (MLTC, 5%).

MLTC consists of four products:

- Partially Capitated Managed Long-Term Care (MLTC Partial): 25 plans that cover long-term services and supports excluding long-term nursing facility stays, covering 249,000 New Yorkers.
- Medicaid Advantage Plus (MAP): 12 of the 25 MLTC Partial plans that offer fully integrated Medicaid and Medicare products to provide physical, behavioral, and long-term care to dual-eligible members under a federal dual special-needs plan (D-SNP) designation, covering 34,000 New Yorkers.
- Program of All-Inclusive Care for the Elderly (PACE): Nine plans offering an integrated Medicaid and Medicare product, covering 7,000 New Yorkers.
- Fully Integrated Duals Advantage for Intellectual and Developmental Disabilities (FIDA-IDD): One plan providing integrated Medicare and Medicaid coverage to approximately 2,000 New Yorkers with intellectual or developmental disabilities.

When considering the Managed Long-Term Care line of business, this report focuses only on the MLTC Partial and MAP products, which comprise 99% of MLTC enrollees.

The plans, their enrollment, and whether they are MLTC Partial (MLTCP) and/or MAP are included in the table below. Of the 25 MLTC plans in NYS, 15 have fewer than 10,000 enrollees and are considered to be a small MLTC plan for the sake of this report.

[1] NYS had 7.6 million total Medicaid enrollment as of July 2022. New York State Medicaid Enrollment Databook, New York State Department of Health, March 2022, https://www.health.ny.gov/health_care/medicaid/enrollment/historical/all_months.htm.

Exhibit 3.1:	NYS MLTC Enrollment by Plan
Data source:	NYS MCO Enrollment Reports, July 2022

Plan Name	MLTCP Enrollment	MAP Enrollment	Total Enrollment	Product(s)	Plan Size (Small: <10K members)
Centers Plan for Healthy Living	47,750	1,260	49,010	MLTCP & MAP	Large
Integra	43,228		43,228	MLTCP	Large
Healthfirst	9,244	22,899	32,143	MLTCP & MAP	Large
VNS	22,142	3,090	25,232	MLTCP & MAP	Large
Fidelis	17,935	379	18,314	MLTCP & MAP	Large
Elderplan	14,797	3,051	17,848	MLTCP & MAP	Large
VillageCare Max	14,663	2,784	17,447	MLTCP & MAP	Large
Elderserve	15,401	118	15,519	MLTCP & MAP	Large
Senior Whole Health	13,951	134	14,085	MLTCP & MAP	Large
AgeWell	13,246	70	13,316	MLTCP & MAP	Large
Extended MLTC	5,483		5,483	MLTCP	Small
Aetna	5,399		5,399	MLTCP	Small
ArchCare	4,943		4,943	MLTCP	Small
HealthPlus	4,734	193	4,927	MLTCP & MAP	Small
iCircle Care	3,554		3,554	MLTCP	Small
VNA Homecare Options	3,524		3,524	MLTCP	Small
Hamaspik Choice	1,962	359	2,321	MLTCP & MAP	Small
Montefiore HMO	1,413		1,413	MLTCP	Small
MetroPlus	1,305	20	1,325	MLTCP & MAP	Small
Elderwood Health Plan	1,038		1,038	MLTCP	Small
EverCare	912		912	MLTCP	Small
Fallon Health Weinberg	849		849	MLTCP	Small
Kalos Health	553		553	MLTCP	Small
Prime Health Choice	549		549	MLTCP	Small
Senior Network Health	340		340	MLTCP	Small
Total Enrollment	**248,915**	**34,357**	**283,272**		

Mainstream is a product offered by 12 non-specialized health maintenance organization (HMO) plans covering 5.4 million New Yorkers.

Health and Recovery Plans (HARP) is a separate product from Mainstream but is offered by 11 of the same 12 plans that offer Mainstream. HARP plans provide care for individuals with severe mental illness and/or a substance abuse disorder; they cover 165,000 New Yorkers. The 12th plan is expected to add HARP enrollment in the coming year.

The below table shows each plan and their enrollment by Mainstream or HARP product.

Exhibit 3.2:	NYS Mainstream & HARP Enrollment by Plan
Data source:	NYS MCO Enrollment Reports, July 2022

Plan Name	Mainstream Enrollment	HARP Enrollment	Total Enrollment

Fidelis	1,743,428	55,614	1,799,042
Healthfirst	1,239,856	32,707	1,272,563
MetroPlus	475,295	13,684	488,979
HealthPlus	392,156	7,937	400,093
United	377,020	10,991	388,011
Molina	313,690	10,059	323,749
Excellus	229,643	11,983	241,626
MVP	209,522	7,996	217,518
HIP	165,374	5,762	171,136
CDPHP	112,057	4,892	116,949
Independent	69,450	2,888	72,338
HealthNow	55,636	-	55,636
Total enrollment	**5,383,127**	**164,513**	**5,547,640**

4 BACKGROUND ON MMC PROGRAM DESIGN AND HOW STATES SELECT AND MANAGE MCOS

Medicaid Managed Care (MMC) is a contractual arrangement between the state Medicaid agency and a managed care organization (MCO). MCO arrangements are intended to improve both the quality and value of care, as well as access, outcomes, and state budget predictability.

As of July 2022, 40 states (plus Washington, D.C.) are delivering Medicaid services through capitated managed care models.[2] For those that have not adopted contracted managed care programs, the state administers Medicaid benefits. In some cases, the state develops value-based payment models (e.g., Vermont's statewide Accountable Care Organization) with a provider organization to achieve similar goals as MCOs.

MMC program design varies widely across states and may differ across multiple dimensions. This results in nuanced models, as described below.

- Product lines: States decide which product lines to include under managed care and how to structure them (e.g., as distinct or integrated lines). Examples include Mainstream, Managed Long-Term Services and Supports (MLTSS), Children's Health Insurance Program (CHIP), and HIV Special Needs Plans (HIV SNPs).
- Populations covered: States decide which populations to cover within managed care. States may carve out certain populations from their MCOs, such as individuals with intellectual and developmental disabilities, children with special needs, children in foster care, people in nursing facilities, and individuals in inpatient psychiatric care facilities.
- Benefits and services provided: States decide which specific services within their offerings are in managed care. States may carve out certain services from MCO plans—including behavioral health, dental, and pharmacy—meaning that the health plan is not responsible for providing or receiving payment for these services.[3] States vary significantly in which services are included versus carved out of comprehensive care.

[2] "Mapping Medicaid Managed Care Models & Delivery System and Payment Reform," Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/. Note: The 10 states without MMC are Alabama, Alaska, Connecticut, Idaho, Maine, Montana, Oklahoma, South Dakota, Vermont, Wyoming.

[3] "Types of managed care arrangements," Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/types-of-managed-care-arrangements.

- Mandatory versus voluntary enrollment: States may obtain a waiver from CMS, such as 1915(b) and 1902, to require some, or all, Medicaid members to enroll in an MCO rather than stay in the fee-for-service (FFS) program. In states with voluntary enrollment, members who opt out continue to be served on an FFS basis.[4]
- Statewide versus regional plan availability: States may seek a waiver (1902) to operate MCOs in specific regions rather than statewide.[5]

Overview of How States Select and Manage MCOs

States take three related actions to select and manage MCOs:

1. Determine which MCOs can provide services to Medicaid members in the state.
2. Set terms for service delivery and standards through a model contract.
3. Enforce that contract through ongoing oversight and evaluation of MCOs against their contractual obligations.

All three of these actions must work in concert together to achieve desired program outcomes.

1. Determining Which MCOs Can Provide Services

States use one of two mechanisms to determine which MCOs can provide services to its members: certification or procurement.

Certification involves setting standards in law or regulation. If an MCO meets the standards, it is permitted to provide services. Importantly, a certification model does not necessarily allow the state to restrict the number of MCOs or decide which MCOs will serve its members.

Currently, NYS uses an "any willing provider" certification model. Certification standards are set primarily in regulation, with additional standards by product line. MCOs can enter the market if they meet the standards and are approved. In contrast, all but five other states (of 41 with managed care) utilize competitive procurement to select their MCOs.

Procurement requires the use of a request for proposals (RFP) that prompts potential MCOs to bid on the services. As with any other government procurement, the state evaluates responses on a set of predetermined criteria to select winners. Winners sign a contract for a set term. At the end of this term, the state re-bids the contract through a new procurement, RFP, and new contract. Procurement allows the state to directly and competitively select which MCOs to provide services to for a given population in a particular region.

A benchmarking of MMC procurements in other states since 2015 and key learnings can be found in Section 10 of the report.

[4] "Enrollment process for Medicaid managed care," Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/enrollment-process-for-medicaid-managed-care.

[5] "Managed Care Authorities," Medicaid and CHIP Payment and Access Commission, https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html.

2. Setting Terms for Service Delivery

In both certification and procurement, requirements for MCOs—such as quality minimums or specifications for provider access—are codified in a model contract. A model contract sets the standards for all plans.

States that use a certification model often codify requirements in the model contract and further specify how they are enforceable. Each individual MCO then signs specific contracts with the state that may vary slightly.

This is the same process used in NYS, with a model contract defining the terms. MCOs then sign individual contracts with DOH to provide services. Authority for any contract provision must be found in Public Health Law and mirror certification standards.

Similarly, states that launch procurements may incorporate their RFP requirements into their model contracts to hold plans accountable for commitments made within their RFP responses. This allows states to use an RFP to test the market and incorporate the most innovative or leading responses into their model contracts, raising the bar for all market participants.

Changes to contracts to increase standards, penalties, and other performance and enforcement mechanisms are an important tool in improving MCO services across states. Examples could include requiring community reinvestment or increasing quality targets to improve overall performance.

3. Enforcing the Contract

Oversight and enforcement are necessary to ensure that standards are being met. Oversight generally consists of governance meetings, data review of key provisions (e.g., network adequacy), and formal processes of review, reporting, sanctions, and penalties, if warranted. For example, states, including NYS, set specific quality measures and targets that MCOs must hit. In NYS, a plan's strong performance on certain quality measures results in a bonus payment. Conversely, in some states, poor performance results in a penalty or a withholding of funding and a plan of correction.

In MCO contract management, and public-sector contract management more generally, states are shifting more and more to active contract management (ACM). ACM is defined by higher-frequency, collaborative, data-informed meetings that focus on consistent performance improvement. It empowers leaders to detect and respond to problems rapidly and to identify opportunities for reengineering service delivery.

Continually improving oversight and performance are foundational to both certification changes and procurement, as there remains a model contract to be enforced in both options.

NYS DOH has several contract management, enforcement, and communication mechanisms that enable state oversight today:

- Ongoing surveillance and quality review, including comprehensive operational surveys (COS), targeted operational surveys (corrective), and focused and ongoing review activities.
- Monthly meetings with MCOs, which cover MMC program updates, initiative-specific updates, and guidance on policy and regulation.
- Sanctions, penalties, and termination, available in law and statute, regulation, and contract.
- Data reviews and quality reviews based on claims data submitted by MCOs.

All three of these elements—determining which MCOs can provide services, setting contract standards, and enforcing contract standards—define the MCO services provided. All three must work in tandem to continually improve those services.

5 METHODOLOGY AND LIMITATIONS

The findings of this report are informed by analyses of publicly available and state-provided data, stakeholder and expert interviews, and desk research.

The purpose of this section is to provide a high-level overview of our analytical approach and its limitations. Specifically, this section covers the selection of peer states, regionalization of NYS, and key quantitative data sources used throughout the report. A detailed explanation of the methodology used for individual analyses is provided in the appendix.

Selection of Peer States

As discussed in Section 4, Medicaid program design varies across states. Recognizing the challenges of comparing states' Medicaid markets given these nuances, this report developed a consistent set of Mainstream and MLTC peer states most similar to NYS based on a set of clearly defined principles for comparability.

These selection principles were defined and applied as of the writing of this report:

- States with MMC:[6] 40 states (as well as D.C.) besides NYS use MMC. This filter eliminated Alabama, Arkansas, Connecticut, Idaho, Maine, Montana, Oklahoma, South Dakota, Vermont, and Wyoming.
- States that have expanded Medicaid:[7] Nine states—Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Wisconsin—have not expanded Medicaid under the Affordable Care Act (ACA). These non-expansion states are excluded, as this core policy decision changes the populations covered in Mainstream and reflects an underlying difference in how state leadership manages the Medicaid program compared to NYS.
- Sufficiently large/urban and programmatically similar:[8] 14 of the 21 remaining states were eliminated due to being either too small and/or too rural to match NYS's demography (i.e., state populations less than five million and/or less than half the population density of NYS) or have major differences in program design that limit comparability (e.g., Massachusetts has a unique model in which provider-led accountable care organizations act as MCOs).

Meeting the above criterion, Pennsylvania, Illinois, California, Michigan, and Ohio were used as peer procurement states, and Maryland and New Jersey were used as peer certification states. These states all have an equivalent to the NYS Mainstream program, and all except Maryland have an equivalent to MLTSS (therefore, Maryland was excluded as an MLTC peer state). Minnesota, Tennessee, and Wisconsin were added as benchmark states for MLTC, despite not passing one or more of the above criterion, as their MLTSS programs have a medical or nursing facility carveout like NYS does.

[6] "Mapping Medicaid Managed Care Models & Delivery System and Payment Reform," Kaiser Family Foundation, March 6, 2023, https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/.

[7] "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/, March 27, 2023.

[8] Population Density of the 50 States, the District of Columbia, and Puerto Rico: 1910 to 2020, U.S. Census, https://www2.census.gov/programs-surveys/decennial/2020/data/apportionment/population-density-data-table.pdf.

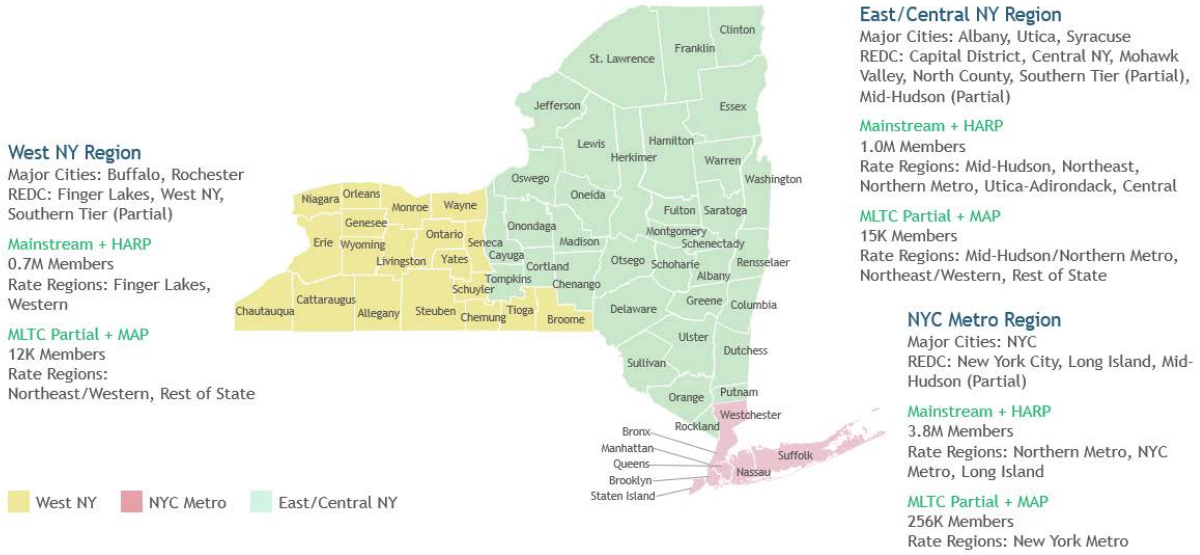
Selected Peer States	MLTC	Mainstream
Procurement States	California, Illinois, Michigan, Minnesota, Ohio, Pennsylvania, Tennessee, Wisconsin	California, Illinois, Michigan, Ohio, Pennsylvania
Certification States	New Jersey	Maryland, New Jersey

These peer states are used for the market composition benchmarking analysis and comparison of program design in Sections 6 and 7, as well as for benchmarking performance on national performance measures where available (e.g., Mainstream quality and cost in Section 7). For other analyses, such as benchmarking recent procurements and identifying examples of contract and contract management best practices in Section 12, we expanded to all states with MMC. Given the particular nuances of the NYS HARP model, an explicit set of peer states was not used; rather, we compare the design of HARP to different state approaches to carving behavioral health into MMC.

Regionalization of NYS

This report segments NYS into three geographic regions based on plan service areas and enrollment patterns: NYC Metro, East/Central NY, and West NY. State enrollment data showed that plans primarily played in one of these three regions or across the entire state. As such, each plan was assigned a regional focus (New York Metro, East/Central NY, West NY, or Whole) based on its member distribution. Additional detail on this methodology is in the appendix. The map below details the regions.

Exhibit 5.1:	NYS Regions for Analysis
Data source:	NYS MCO Enrollment Reports, July 2022



Data Utilized to Evaluate MCO Services

This report leveraged a variety of data sources wherever available. We have noted where data was available by product and by state. Years of data used are noted in data tables throughout the report.

The table below details the key quantitative data sources used in analyses. Other sources, such as publicly available data from desk research, are footnoted throughout the report.

	Data	Date	Products	Use case	Content	Provided by
Enrollment	NYS MCO Enrollment	July 2022	MLTC Partial, MAP, Mainstream, HARP	Market composition, plan size, and list of plans	The number of managed care plans, and enrollees, by state and region.	NYS DOH Website
	Peer State MCO Enrollment	Latest available	Peer states	Market composition and plan size	Across peer states, regions of comparable density to NYC Metro and the rest of NYS were manually defined, and enrollment by plan was sourced and assessed at the county and region level.	State websites and CMS data
Member Metrics	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	2021 for NYS & national data, 2020–2021 for peer states	Mainstream, HARP, peer states	Members' satisfaction with plans	National survey that assesses member satisfaction with health care services, including health plan ratings and customer service ratings. Benchmarks included statewide averages of health plan and satisfaction ratings from peer states.	State websites, 2021 SPH Analytics report[9] & CA report[10] for national data
	Newly Eligible Member Enrollment	2019–2021	MLTC Partial, MAP, Mainstream, HARP	Members' affirmative plan selection rates (versus auto or passive/default enrollment)	Individual member enrollment records, including enrollment date, enrollment type, plan name, line of business, and county.	OHIP
	Plan Changes	2019–2021	MLTC Partial, MAP, Mainstream, HARP	Members' revealed preferences for plans	Individual member enrollment records, including current and previous enrollment date, enrollment type, plan name, line of business, and county.	OHIP

[9] 2021 Medicaid Adult CAHPS 5.1H At-A-Glance Report, SPH Analytics, July 2021, https://www.healthpartnersplans.com/media/100734242/2021-adult-medicaid-cahps-report.pdf.

[10] 2021 CAHPS Medicaid Managed Care Survey Summary Report, California Department of Health Care Services, March 2022, https://www.dhcs.ca.gov/Documents/MCQMD/2021-Medicaid-Managed-Care-Survey-Summary-Report.pdf.

	Member and Provider Complaints	2021	MLTC Partial, Mainstream	Members' complaint rates by plan	Complaints collected via phone or email by DOH's Bureau of Consumer Services or the Bureau of Managed Long-Term Care regarding any MCO services. Complaints logged with the state only, not with individual MCOs.	OHIP
Quality Metrics	NCQA Healthcare Effectiveness Data Information Set (HEDIS) quality metrics	2022	Mainstream, peer states	Quality performance & outcomes by plan	Performance against HEDIS quality metrics by plan (NYS only) or state are used by over 90% of U.S. health plans (Commercial, Medicare, Medicaid plans) to measure quality and access.	NYS data provided by OHIP; benchmark states provided by NCQA and cannot be published
	NYS Quality Assurance Reporting Requirements (QARR) quality metrics	2019–2021	Mainstream, HARP	Quality performance & outcomes by plan	Quality performance of Mainstream plans (all metrics), change over time of performance against BH metrics for HARP plans.	NYS DOH website
	NYS MLTC External Quality Review (EQR) Report	Report 2023, data 2021	MLTC Partial	Subset of quality metrics by plan	Performance on quality measures by plan, for plans with Performance Improvement Project (PIP).	NYS DOH website
	NYS Consumer Guide Plan Ratings	2019	MLTC Partial	Quality performance & outcomes by plan	Rating by plan published by NYS to assist consumers in plan selection; plans are rated 1–5 stars, where 5 indicates highest quality.	NYS DOH website
Provider & Claims Metrics	NYS Provider Network Data System (PNDS)	January 2023	MLTC Partial and MAP (LHCSAs), Mainstream, HARP	Index of contracted providers and LHCSAs	Directory of providers and LHCSAs by NPI, line of business, plan, and county.	OHIP
	PNDS BH Network Reporting Data	Q4 2022	Mainstream, HARP	Adequacy of BH service networks	County, line of business, and plan-level data showing network adequacy standards for BH services along with indicators showing whether plans are compliant in each county.	OMH

	Aggregated Claims Data	April 2021–March 2022	MLTC Partial, MAP, Mainstream, HARP	Which providers bill to which plans	Count and dollar amount of claims by line of business, plan, provider NPI, claim class, and claim type.	OHIP
Financials	MCO Aggregate Financial Reports	2019	MLTC Partial, MAP, Mainstream, HARP	Plan revenue, profitability, and ALR	Net and premium P&L and revenue, total and PMPM, by plan, plus breakdown of plan revenue into medical loss, administrative loss, and underwriting ratio (profit).	OHIP
	Milliman MMC Financial Results	2019	Mainstream, peer states	Administrative loss ratio (ALR) benchmarking	Average administrative loss ratio by state for select states.	Milliman public report
BH	Internal state reports and documentation related to BH	Varies, 2016–2023	Mainstream, HARP	BH performance and challenges	BH case reviews, surveys, compliance reports, legislative reports, utilization dashboards, financial and claims analyses.	OMH

Limitations

Throughout this report, we have endeavored to compare NYS MCO services and performance to other states. However, that exercise has several challenges, such as:

- Lack of comparability across Medicaid programs: No two Medicaid programs are exactly alike. Under federal law, states can experiment and design their managed care programs differently. Such differences in state programs are explained below:
    - Some states are fully fee-for-service and do not utilize managed care.
    - Not every state uses MLTC or an MLTC equivalent. Further, since each state defines its MTLC program populations and services differently (see Section 6), comparisons are difficult.
    - Not every state uses a separate behavioral health product like HARP.
    - The geographic span of MCO coverage varies, with some states using regional MCOs and other requiring statewide coverage of MCOs.
    - Some states have chosen not to expand Medicaid under the Affordable Care Act (ACA) the way NYS has.
- Data availability: Depending on the state, region, line of business, or product, data may not be available or comparable.
    - Data available for NYS may not be publicly available for other states to allow for comparisons. Even if data is available, metrics may be defined and measured differently than NYS, thereby limiting direct comparison.
    - Data may be collected only at a statewide level, not regionally. Collecting regional data is important because not all plans in NYS or in other states operate in every county.

- Data may be available for some products or lines of business, and not others. In other words, while certain data may be available for Mainstream, it may not be available for MLTC.

Ideally, this report could have considered another state that previously used certification and then switched to procurement in both Mainstream and MLTC. However, given that 34 states procure managed care (shifting from fee-for-service) and 10 states do not have managed care, we found no examples of a state moving from a certification or "any willing plan" model to procurement in Mainstream or MLTC that would allow for direct impact analysis of such a shift.

6 EVALUATION OF THE MLTC LINE OF BUSINESS

To evaluate the MLTC line of business, this report:

- **Compares NYS's MLTC program design to peer states.** This provides context on the key nuances of each benchmarked state's individualized model.
- **Compares NYS's MLTC market composition to peer states** to address the legislature's request for "a market assessment of the MCOs offering products in each market, including the appropriate number of managed care organizations to each region to address member needs."
- **Assesses current performance and challenges in the NYS MLTC market** to cover the legislature's request for an "analysis of areas of potential improvements or challenges…that may result from competitive procurement."

Comparison of NYS's MLTC Program Design to Peer States

States have increasingly adopted managed care instead of fee-for-service in their LTSS offerings to provide greater and more predictable access, particularly for home- and community-based services. This also yields improved health outcomes, member experience, and budget predictability. States with MLTC programs contract with MCOs to deliver managed long-term services and supports (MLTSS) for individuals with extra needs as well as for beneficiaries who are dual-eligible. As of 2021, 24 states operated MLTSS programs, up from eight states in 2004. [11]

State models for implementing MLTSS vary widely. States can choose how to structure their programs based on the following dimensions:

- Populations included: Populations that may be included can be based on age (seniors) or clinical need (e.g., individuals meeting a nursing facility level of care, or members with physical, intellectual, or developmental disabilities). States may choose to combine all these populations in one product or have separate products.
- Allowance for choice: Some state programs are mandatory, meaning that Medicaid members are required to enroll in an MCO if they are eligible for the services and in a covered population. Others are voluntary; individuals in those states who do not select an MCO remain in traditional Medicaid fee-for-service.
- Geographies offered: Some states have statewide programs, whereas others have programs at a county or regional level only.

[11] "Managed long-term services and supports," Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/.

- Services covered: States make two major decisions on what to include in their MLTSS programs. First, do they offer long-term care services with physical and/or behavioral health in one comprehensive program, or do they offer those services separately? Second, do they offer the full range of long-term care services, or do they exclude some services (e.g., nursing facility stays)? This results in three types of models: 1) Comprehensive medical, behavioral, and long-term care benefits, 2) comprehensive long-term care, and 3) selective long-term care.
- Alignment with Medicare: For dual-eligible beneficiaries, several potential programs to align Medicaid and Medicare must be considered. States can offer MLTSS as part of these Medicare-aligned products or separately. Generally, these products fall under one of two federal designations: the Financial Alignment Initiative (FAI) or dual-eligible special needs plans (D-SNPs), which have several different designations.

Based on those dimensions, states often implement multiple MLTSS programs to cover combinations of populations and services. NYS's MLTC Partial Capitation (MLTCP) and Medicaid Advantage Plus (MAP) programs are two examples.

For its MLTCP product, NYS has made three core design choices: 1) providing long-term care benefits only, rather than including medical benefits; 2) excluding nursing facility stays of more than 90 days; and 3) not mandating integration with Medicare. In contrast, other states—such as Michigan, New Jersey, Illinois, and Ohio—have service packages that include physical and behavioral health, along with long-term care. Still other states—California and Pennsylvania—have MLTSS programs that separate long-term care from physical and behavioral health but include nursing facilities.

MAP is a federally aligned Medicare D-SNP for dual-eligible members. Medicare-aligned products are more standardized nationally as they must follow a set of federal rules. Accordingly, NYS has made fewer independent design choices with MAP than it has for MLTCP, and many states have MAP equivalents. Unlike MTLCP, MAP provides both physical and behavioral long-term care, and the Medicaid product is fully integrated with Medicare.

MLTSS model differences across states make benchmarking more complicated and require a deeper understanding of the individualized models for states. This may limit generalizability.

The following table briefly summarizes the MLTSS model used by each benchmarked state. As explained in Section 5, this includes all Mainstream peer states with an MLTSS program (California, Illinois, Michigan, New Jersey, Ohio, and Pennsylvania), as well as the only three other states with carveouts comparable to those of NYS's MLTCP (Wisconsin, which has a medical carveout in MLTSS, and Tennessee and Minnesota, which carve out nursing facility stays beyond a certain number of days).

Exhibit 6.1:	MLTSS Model Design Benchmarking
Data source:	State Websites, Latest Year Available

	State	Population	Choice	Geography	Services	Medicare Alignment
	NY	Dual-eligible adults 21+	Mandatory	Statewide for MLTCP Regional for MAP	Long-term care only Excludes nursing facilities for MLTCP	MAP program is fully-integrated D-SNP
Mainstream Peers	CA	Over 65+	Voluntary	Regional	Long-term care only	D-SNPs available regionally
	IL	Adults 21+	Mandatory	Regional	Comprehensive long-term care, physical and behavioral health	D-SNPs not available
	MI	Dual-eligible adults 21+	Voluntary	Regional	Comprehensive long-term care, physical and behavioral health	D-SNP is the only offered MLTSS product
	NJ	Dual-eligible adults 21+	Voluntary	Statewide	Comprehensive long-term care, physical and behavioral health	Fully-integrated D-SNP
	OH	Dual-eligible adults 21+	Mandatory	Regional	Comprehensive long-term care, physical and behavioral health	D-SNPs available regionally
	PA	Adults 21+ needing nursing facility level of care	Voluntary	Statewide	Long term care only	Fully-integrated D-SNP
MLTSS Carveouts	MN	Dual-eligible adults 65+	Voluntary	Statewide	Long term care excluding nursing facilities over 180 day stay Includes physical and behavioral health	Statewide fully-integrated D-SNP
	TN	Dual-eligible adults 21+ and individuals with developmental disabilities	Mandatory	Statewide	Long term care excluding nursing facilities Includes physical and behavioral health	Statewide fully-integrated D-SNP
	WI	Adults 21+ with disabilities and adults 65+	Voluntary	Regionally	Long-term care and BH only	D-SNP available regionally

Comparison of NYS's MLTC Market Composition to Peer States

Per the legislature's request to provide a market assessment, this analysis evaluates the number of plans in the region and enrollment per plan across peers. Markets with a large number of plans and low enrollment per plan can be considered fragmented. For the list of plans in the NYS market and their respective enrollment, see Section 3.

This analysis benchmarks specific regions within states for three reasons. First, not every MCO provides services in every county in a state, so describing a state as a whole misrepresents the true nature of the market. Second, since not every plan provides services in every county, not every member has the same choice of plans. Considering regional markets, on average, better describes the member experience. Third, some benchmarked states offer MLTC programs only regionally and not statewide.

This report segments NYS into three geographic regions based on plan service areas and enrollment patterns: NYC Metro, East/Central NY, and West NY. In the following market benchmarking analysis, NYC Metro is compared to major cities within peer states. East/Central NY and West NY are analyzed together (as "Rest of NYS") against comparable exurban areas within peer states.

New Jersey does not split enrollment by region, which would have allowed for a more specific comparison; it is compared against NYC Metro. While Tennessee was included as an MLTC peer state given its nursing facility carve-out, information to benchmark its market composition was not available, and thus it is excluded.

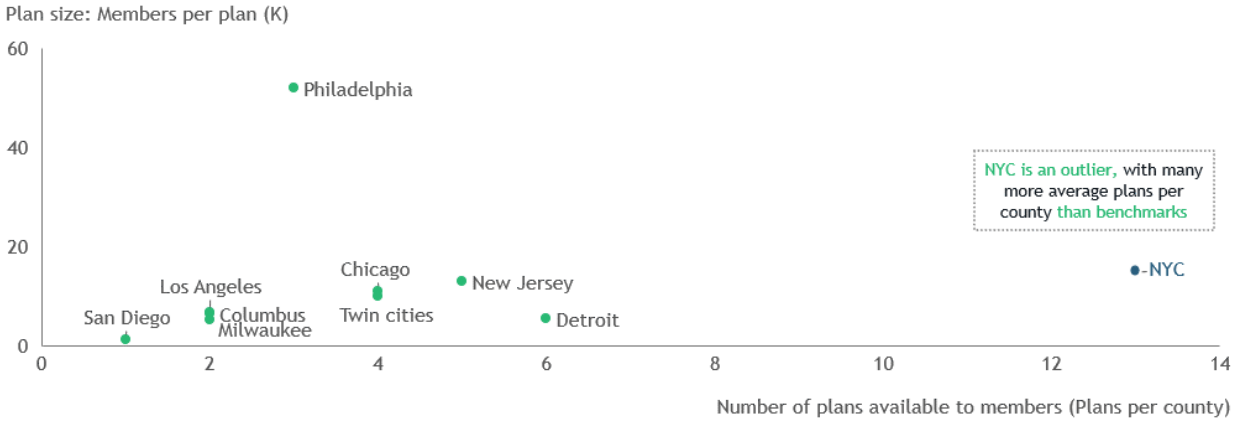
Overall

NYS's MLTC program has 25 MCOs. NYS has more plans than peer states, and many of those plans have low enrollment (fewer than 1,000 members) per plan.

NYC Metro

NYC Metro has 17 plans. On average, members can choose from 13 plans (not all plans are offered in every county in the metro region). There are, on average, 15,000 enrollees per plan, with a range of enrollment per plan from 300 to 48,000 enrollees. In contrast, comparable metro areas in peer states have one to six plans (in total, and on average available to members), averaging 1,300 to 52,000 members per plan. NYC therefore has more than double the number of plans to choose from and relatively low average enrollment per plan compared to benchmarked peers. A detailed breakdown of market composition is in the graph below.

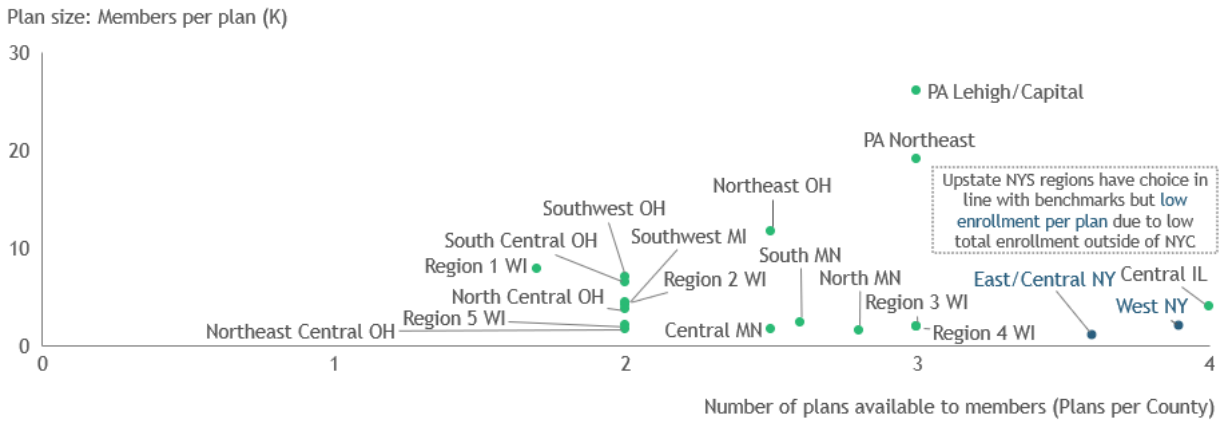
Exhibit 6.2:	MLTC Fragmentation Benchmarking – Major Metro Areas (Plan Size & Number of Plans)
Data source:	Benchmark State Enrollment Reports, Procurement Regions, and Census Data; Latest Month Available



Rest of NYS

West NY has eight plans, and East/Central NY has 12 plans. In each region, members can choose from three to four plans available to them on average. There are an average of 1,400 enrollees per plan, with a range of 30 to 5,400 members. In contrast, comparable regions have two to seven plans total, and members have on average two to four plans available to them. Average enrollment per plan ranges from 1,600 to 26,000 enrollees. Accordingly, the number of plans available for members to choose from in the rest of NYS is comparable to benchmark regions, but NYS plans are smaller on a per-enrollee basis. This reflects the low number of MLTC members outside NYC broadly, as roughly 90% of MLTC enrollment is concentrated in NYC Metro. A detailed breakdown of market composition is in the graph below.

Exhibit 6.3:	MLTC Fragmentation Benchmarking – Exurban Areas (Plan Size & Number of Plans)
Data source:	Benchmark State Enrollment Reports, Procurement Regions, and Census Data; Latest Month Available



Assessment of Current Performance and Challenges in the NYS MLTC Market

As detailed above, NYS has more MLTC plans than peer states, and many of those plans have low enrollment (less than 1,000 members) per plan.

The presence of so many plans in the MLTC market and the existence of low-enrollment plans contributes to several challenges. Namely, plans with low enrollment have 14% higher per-member administrative costs than those with high enrollment. Low-enrollment plans are also less profitable, are less likely to offer aligned Medicare products, are more likely to be rated one star (lowest) by the state, have 25% higher complaint rates on average, and are losing enrollment from members choosing to change plans. Meanwhile, the large number of plans in the market increases provider contracting and billing burden while stretching state resources for contracting and oversight.

The MLTC market faces other challenges beyond market composition. Key challenges include quality issues and gaps in quality measurement, limited alignment with Medicare, and shortages of medical at-home workers and limitations of the existing network adequacy standards.

These challenges were identified based on an analysis of the data detailed in the Methodology section. However, this list is not necessarily exhaustive because not all benefits and challenges can be measured and quantified with the data available. For example, plans that are closer to the communities they serve may deliver more culturally competent care that improves member experiences in ways not fully captured in this report's analysis.

Further details on these challenges are covered below. Where possible, the analyses compare NYS to other states. However, given the significant nuances in MLTC program design across states, as well as the use of proprietary NYS data that is not necessarily measured equivalently and/or published by other states, the opportunities to draw such comparisons were limited. For example, difficulty of cross-comparable MLTSS quality data is a nationwide issue, with CMS just releasing its first ever voluntary Home- and Community-based Services (HCBS) quality measures in July 2022.

Low Enrollment Plans

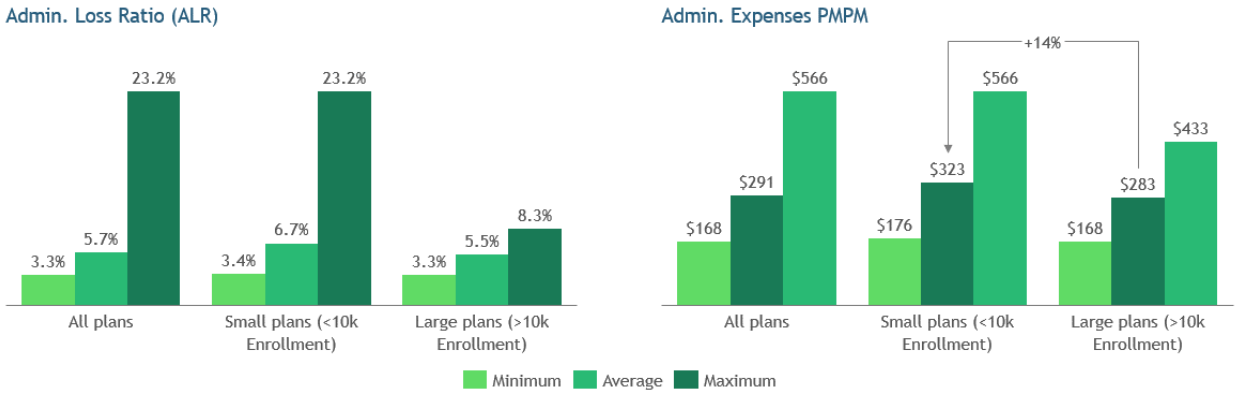
Under its certification model, NYS does not select the number of plans that can serve members. Instead, any plan that meets the requirements can enter the market. This leads to a large number of plans, with some serving few members. As noted above, of the 25 MLTC plans in NYS, 15 have fewer than 10,000 enrollees (this report's definition of a small plan), and five have fewer than 1,000 enrollees. As

demonstrated in the market composition benchmarking, plan size is particularly low Upstate (averaging 1,000 to 2,000 enrollees per plan in NYS Upstate versus 1,600 to 26,000 enrollees per plan for peer exurban regions).

Small plans underperform large ones on several state goals.

- Administrative costs: Small plans have higher administrative costs on average per member. Insurance uses administrative loss ratio (ALR) as a measure of administrative costs, which is represented as a percentage of total revenue. Based on 2019 data, small MLTC plans have an average ALR of 6.7% versus an average of 5.5% for large MLTC plans. On a per-member per-month (PMPM) basis, this translates to small plans spending 14% more of their revenue on administrative costs than large plans. Details on NYS MLTC plans' ALRs are shown in the figure below.

Exhibit 6.4:	MLTC Partial Administrative Costs by Plan Size
Data source:	MCO Financial Reports, 2019; MCO Enrollment (for plan size), July 2022



- Profitability: Two of 10 large plans were unprofitable in 2019, while 13 of 16 small plans present in the market in 2019 were unprofitable. (Note: The profitability analysis was conducted using 2019 data to avoid COVID-19-related noise. In 2019, there were 26 total MLTC plans; in 2020, WellCare was purchased by Fidelis, resulting in the 25 plans present in 2021–2022). Small plans also vary widely in profitability, ranging from a profit of roughly $600 per member per month to losses of $500 per member per month. Conversely, the two unprofitable large plans had lower losses in 2019—$140 per member per month and $76 per member per month. The unprofitability of small plans raises the risk of fiscal insolvency and plans needing financial bailouts from the state.

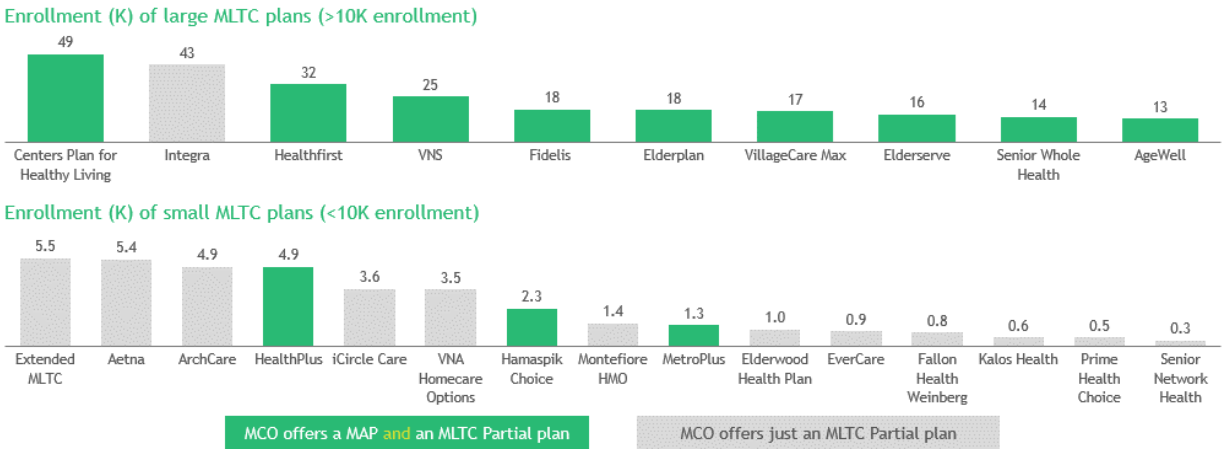
Exhibit 6.5:	MLTC Partial Administrative Costs & Profitability
Data source:	MCO Financial Reports, 2019; MCO Enrollment (for plan size), July 2022

Plan name	Member Months	Revenue PMPM	Admin Costs	ALR	Premium Income	Plan Size
Centers Plan for Healthy Living	422,689	$5,305	$318	6.0%	$295.22	Large
Fidelis	280,532	$5,124	$168	3.3%	$335.95	Large
Integra	243,271	$4,450	$245	5.5%	$528.31	Large
VNS	209,937	$6,378	$341	5.3%	$265.44	Large
Healthfirst	180,233	$5,369	$254	4.7%	$41.58	Large

Elderserve	175,958	$5,316	$224	4.2%	$ (140.27)	Large
Senior Whole Health	177,661	$4,664	$297	6.4%	$205.67	Large
Elderplan	172,757	$5,197	$433	8.3%	$160.48	Large
AgeWell	140,207	$5,266	$204	3.9%	$219.87	Large
VillageCare Max	140,887	$4,645	$380	8.2%	$(76.22)	Large
Aetna	92,692	$5,126	$326	6.4%	$(213.48)	Small
VNA Homecare Options	91,490	$5,897	$207	3.5%	$(135.09)	Small
Extended MLTC	80,662	$4,269	$340	8.0%	$(126.37)	Small
HealthPlus	79,297	$5,158	$566	11.0%	$(538.16)	Small
EverCare	68,635	$5,133	$359	7.0%	$(110.90)	Small
ArchCare	57,667	$5,627	$279	5.0%	$(121.53)	Small
iCircle Care	45,806	$4,040	$289	7.1%	$(523.28)	Small
Hamaspik Choice	28,081	$4,155	$227	5.5%	$(93.31)	Small
MetroPlus	23,775	$5,207	$176	3.4%	$167.83	Small
Montefiore HMO	20,274	$4,963	$439	8.9%	$(145.30)	Small
Kalos Health	17,252	$4,730	$190	4.0%	$(9.64)	Small
WellCare	11,602	$3,966	$434	10.9%	$(440.92)	Small
Fallon Health Weinberg	10,952	$4,209	$268	6.4%	$582.30	Small
Elderwood Health Plan	9,106	$4,232	$411	9.7%	$451.15	Small
Senior Network Health	6,863	$3,396	$329	9.7%	$72.44	Small
Prime Health Choice	5,935	$3,171	$736	23.2%	$(250.92)	Small

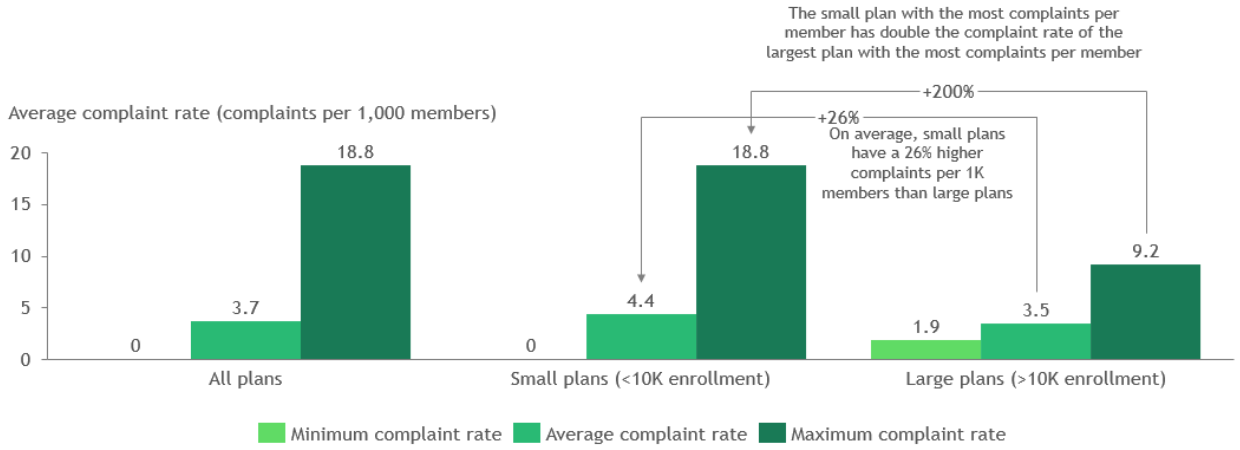
- Quality: Based on NYS's 2019 Consumer Guide plan ratings (the latest available), five of 15 small plans have the lowest quality rating, one star, whereas no large plans are rated one star. This is further explored in the Quality section below.
- Member experience: Three analyses point to a suboptimal member experience in small plans relative to large plans.
    - **Less integrated with Medicare**: Small plans are less likely to offer Medicare-integrated plans for members who are eligible for both, thus requiring members to carry two insurance cards. Of the 15 small plans with fewer than 10,000 enrollees, only three offer the integrated MAP product. Conversely, of the 10 large plans, all but one offer the integrated MAP product. Details on NYS MLTC integrated offerings are summarized in the chart below. Broader limitations in integrated care program-wide and the implications of this for state goals are detailed below under Limited Care Integration.

Exhibit 6.6:	Total MLTC Enrollment (K) & Presence of an Aligned MAP Plan by Plan Size
Data source:	MCO Enrollment, July 2022



- **Higher complaint rates**: Small plans have 26% more member complaints per enrollee on average than large plans (4.4 complaints per 1,000 members for small plans, versus 3.5 for large). The range in small plan complaint rates is also wider than large plans; the small plan with the most complaints per member has a rate that is double that of the large plan with the highest rate (18 versus nine complaints per 1,000 enrollees). Details on NYS MLTC plan member complaints per enrollee is shown in the chart below.

Exhibit 6.7:	MLTC Partial Complaint Rate by Plan Size
Data source:	Member Complaints, 2021; MCO Enrollment (for plan size), July 2022



- **Higher member outflow:** NYS and federal regulations allow members to change plans in certain circumstances after initial plan selection, or a year after initial plan selection. Small plans have a net annual member outflow of 3.0% (i.e., more members leaving than joining), while large plans have a net annual member inflow of 0.5%. This indicates that when members make the proactive decision to change plans and "vote with their feet," they opt for large plans more frequently. Given that 98%+ of plan changes assessed were among members who stayed within the same county, local plan availability is not a driving factor in members' preference toward large plans. NYS net annual member inflow and outflow rates by plan are summarized in the chart below.

Exhibit 6.8:	Rate of MLTC Members Leaving vs. Joining Plans by Plan Size
Data source:	Plan Changes, 2021; MCO Enrollment (for plan size), 2022

Large Number of Plans

NYS has 25 MLTC plans overall. As discussed in the market composition benchmarking, NYS has more plans than peers, especially in NYC Metro. NYS Metro has 17 total plans and an average of 13 available to members, more than double the next closest state's average of six plans to choose from. While Upstate plan choice is relatively in line with peers, the large number of total plans Upstate (eight to 12, compared with two to seven for peers) still generates challenges.

Having many plans in the market contributes to multiple challenges.

- Provider experience: Having more plans in the market increases provider burden since each plan has its own administrative processes. In the NYS MLTC market, more plans mean more provider contracts. In NYC Metro, 33% of LHCSAs contract with five or more plans, which is greater than the number of total plans in most peer state markets. Conversely, 5–10% of Upstate LHCSAs contract with five or more plans. Contracting with more plans generally means providers must bill more plans, exacerbating provider administrative burden on an ongoing basis. Complaint data show that billing is a major pain point for providers (60% of provider complaints are about reimbursement and billing). In MLTCP, LHCSAs contract with an average of 3.6 plans and bill to an average of 4.4 plans, and in MAP, LHCSAs contract with an average of 3.3 plans and bill to an average of 3.0 plans. Histograms of how many plans LHCSAs contract with in MLTCP and MAP are shown below.

Exhibit 6.9:	Contracting Burden of MLTC Partial LHCSAs (Number of Contracted Plans by Percentage of LHCSAs)
Data source:	LHCSA Index, 2023

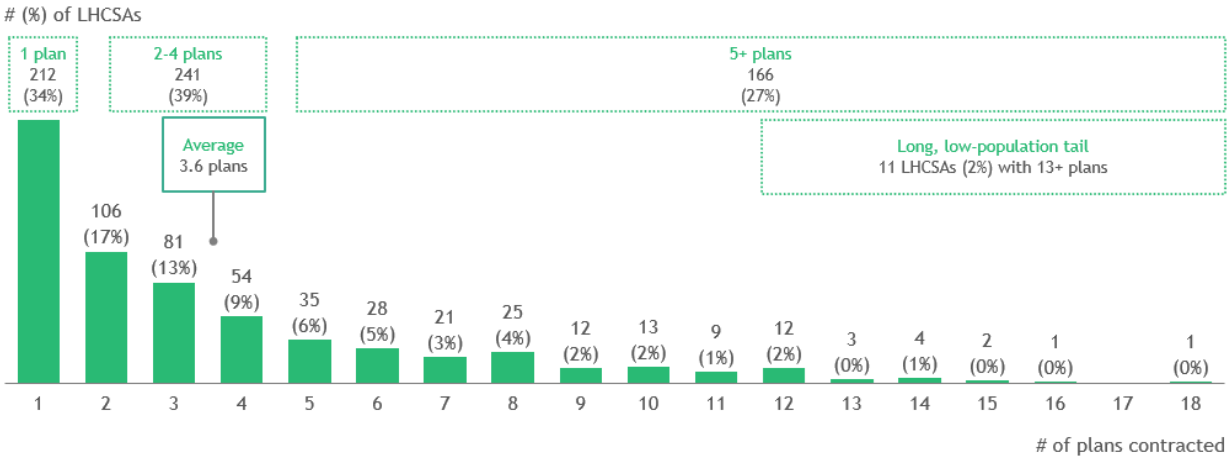


Exhibit 6.10:	Contracting Burden of MLTC Partial LHCSAs by Region (Number of Contracted Plans by Percentage of LHCSAs)
Data source:	LHCSA Index, 2023

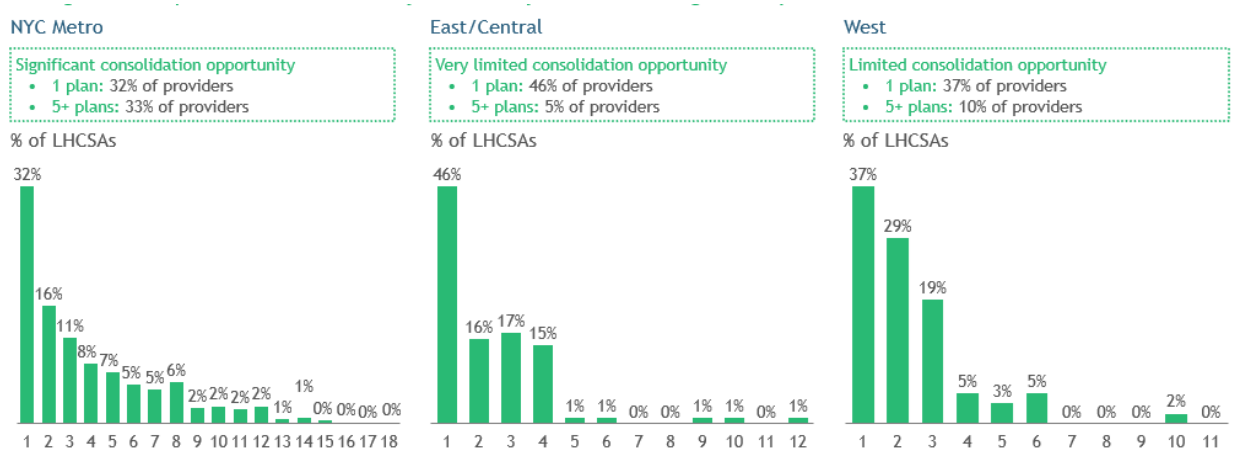
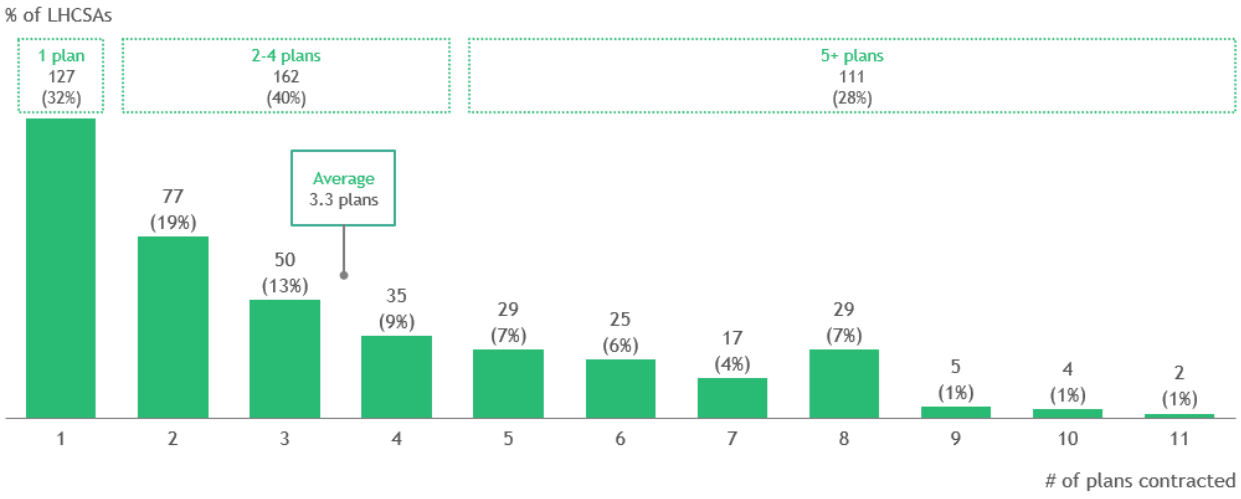


Exhibit 6.11:	Contracting Burden of MAP LHCSAs (Number of Contracted Plans by Percentage of LHCSAs). Note: No regional view, given focus of MAP in NYC Metro.
Data source:	LHCSA Index, 2023



- Member experience: Despite having more plans to choose from than other regions, MLTCP members in NYC Metro have a higher rate of being either auto-assigned or passively/default enrolled into their plans (28% in NYC Metro, versus 17% in West NY and 9% in East/Central NY). This means that members in NYC do not take advantage of all the options available to them. Given a lack of member-level data, this report can only speculate about the factors that may be driving this pattern, but it hypothesizes, based on available behavioral science literature, that NYC Metro members may face a "paradox of choice": The abundance of options confuses members and makes informed choice challenging. This leads them to forego the opportunity to actively pick a plan. NYC Metro also has a 2x higher member plan change rate than other regions. This suggests that, when presented with many plans, members do not fully understand their option set initially and then change plans later. Alternatively, it may indicate that, where there are more plans, members are more likely to shop around and be subject to more advertising or other efforts from plans to entice a plan change. Regardless, the result is more member transition and churn.
- State oversight: If the Office of Health Insurance Programs (OHIP) had fewer plans to oversee, it could better engage in active contract management to improve services and thereby performance on all program goals. OHIP would also be better equipped to sanction MLTC plans that do not meet contractual standards, if necessary. In Mainstream, OHIP conducts biannual surveys for compliance, but in MLTC, they are behind the two-year goal due to resource constraints. Contract management is explored further in Section 12.

Limited Care Integration

Integrated care is defined as a member receiving both Medicare and Medicaid services through the same MCO. In NYS, integrated care is provided through the 12 MAP plans that offer fully integrated Medicaid and Medicare products to provide physical, behavioral, and long-term care to dual-eligible members. In contrast, any dual-eligible members enrolled in one of the 13 MLTCP plans that do not offer a Medicare Advantage–aligned plan must receive their Medicare coverage through another Medicare MCO or through FFS. Integration has been limited in NYS. Even though 85–90% of MLTC members were dual-eligible for Medicare and Medicaid (based on 2019 data),[12] up to 84% of dual-eligible MLTC members would require a plan or carrier change for integrated care with Medicare (based on 2021 data). For more, see table "Percent of Duals by Integration Level" in the Appendix.

Integrated care implemented properly brings benefits to members, providers, MCOs, and the state.

- Benefits to members:
    - **Simplified, enhanced processes for care coordination and primary care access**. For example, with integrated care, members can have a single interdisciplinary care team. This is especially important for dual-eligible members, who are more likely to have chronic conditions. A March 2023 MACPAC focus group on experience with integrated care for dual-eligible beneficiaries that included NYS found that focus group participants readily accessed primary and urgent care. One focus group participant from NYS was quoted as saying "I have a great relationship with [the PCP] now…. And I don't have a

[12] https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2019.pdf, showing 85.1%; https://www.health.ny.gov/health_care/medicaid/redesign/integrated_care/docs/2019-08-13_stakehlder_session3.pdf, showing 90%.

problem getting an appointment. If I need an appointment the same day, I'm able to get in. So that makes a big difference."[13]

- **Better care outcomes**. A 2015 multistate study suggests that integrated plans show favorable outcomes in many areas as compared to regular Medicare Advantage plans, including reduced utilization of institutional LTSS, increased utilization of HCBS, reduced rates of hospitalizations, and reduced mortality. A follow-up study in 2022 found that integration increased HCBS use, decreased institutional use, and improved mortality.[14] It did find increased inpatient hospitalization in fully integrated D-SNP plans, but not for other forms of integrated care like PACE. Research also suggests integration can reduce duplication of services and cost shifting.[15]
- **More efficient appeals and grievances processes** that allow a member to submit paperwork to a single MCO.

- Benefits to providers:
  - **Continuity of care enabled by overlapping provider networks**. Based on NYS's 2022 Dual Eligible Integrated Care Roadmap, D-SNPs are required to have 80% overlapping Medicare/Medicaid networks by January 2024.
  - **Streamlined administrative processes**, including billing to a single MCO for dual-eligible members.
- Benefits to MCOs:
  - **Administrative efficiencies**, such as through simplified billing and appeals and grievances processes, could lead to reduced administrative costs.
- Benefits to the state:
  - **Lower costs**. Despite comprising ~14% of all Medicaid beneficiaries, dual-eligible members enrolled in both Medicare and Medicaid make up a third of Medicaid costs nationally.[16] Through improvement of care coordination and administrative efficiencies, integrated plans can reduce costs for dual-eligible members.

NYS is actively advancing its roadmap to increase integrated care for dual-eligible members, with initiatives including increasing default enrollment of dual-eligible MLTC members into MAP. However, under the state's current certification standards, there is no mechanism to drive more MCOs to offer MAP plans. This constrains the number of integrated offerings in the market.

Quality Issues and Gaps in Existing Quality Measurement

To measure quality in MLTC, NYS has defined a Consumer Guide MLTC plan rating, which is a rating of one to five stars (one lowest, five highest) based on plans' relative performance on 50+ measures[17] across 19 domains[18] related to outcomes, process, and experience of care.

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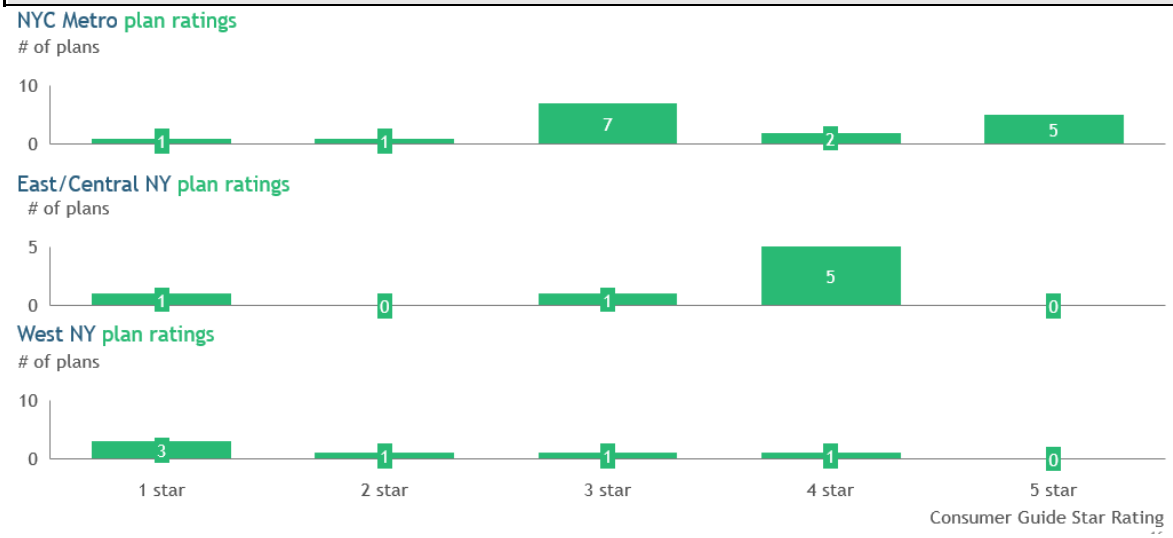
[13] Tamara Huson and Kirstin Blom, "Focus Group Findings: Experience of Full-Benefit Dually Eligible Beneficiaries in Integrated Care Models," MACPAC, March 2, 2023.
[14] Zhanlian Feng, Angela Gasdaska, Joyce Wang, William Haltermann III, and Jhamirah M. Howard, "Can Integrated Care Models Deliver Better Outcomes for Dually Eligible Beneficiaries?" https://www.healthaffairs.org/content/forefront/can-integrated-care-models-deliver-better-outcomes-dually-eligible-beneficiaries.
[15] DC Grabowski, *Medicare and Medicaid: Conflicting Incentives for Long-Term Care*. Milbank Q 2007;85:579-610.
[16] Maria Peña et al., "A Profile of Medicare-Medicaid Enrollees," Kaiser Family Foundation, January 31, 2023, https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.
[17] 2019 Managed Long-Term Care Report, New York State Department of Health, https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2019.pdf.
[18] MLTC Consumer Guide Domains, New York State Department of Health, https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/domains.htm.

The 2019 Consumer Guide plan ratings—the most recent year available—detailed in the graph below show that plan performance varies widely. Plan quality is worse Upstate, where there are a greater share of one-star plans and no five-star plans. Meanwhile, NYC Metro has five five-star plans. In West NY, half of the available plans (three of six) are rated one star. Furthermore, as discussed previously, all five of the 25 MLTC plans that score one star are small plans. These findings demonstrate that, under the current certification model and contract standards, low-quality plans manage to endure in the market, with limited incentive to improve quality. Contract quality standards are explored in Section 12.

Exhibit 6.12:	MLTC Partial Plan Star Ratings by Region (Number of Plans with Each Star Rating)
Data source:	NYS Consumer Guide, 2019



The Consumer Guide ratings reflect the most recent full assessment of MLTC quality metrics. However, additional quality data is reported in the state's External Quality Review (EQR) report, which contains quality performance measures for plans with Performance Improvement Plans (PIPs). These PIPs further reveal wide variation in quality performance among MLTC Partial plans. For example, 30-day readmission rate ranged 7% to 24% (a spread of over 3x) and potentially avoidable hospitalizations rate ranged from 0.02 to 5.38 (a spread of ~250x).

Beyond issues with current quality performance, NYS's existing quality-measurement system for MLTC has two major limitations: Measures are not tied to national standards and are not up to date. First, the Consumer Guide ratings are not fully comparable to other states. Instead, the underlying measures are linked to the NYS-specific Uniform Assessment System Comprehensive Health Assessment (UAS-NY CHA). NYS developed the Consumer Guide quality measurement system for MLTC given a historical lack of national standard measures in MLTSS. Furthermore, the state's EQR quality investigation did not analyze MLTC until 2021, with results published in its 2023 report, and these reports only publish a consistent set of quality measures for plans with PIPs.

However, in 2022, CMS released for the first time HCBS measures recommended for adoption by all states.[19] CMS measures have several advantages that warrant consideration by NYS:

- Benchmarkable against other states: NYS's measures are a homegrown, state-specific solution and therefore cannot be benchmarked to national measures or other states, as is possible in

[19] Center for Medicare & Medicaid Services letter to State Medicaid Directors, July 21, 2022, https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.

Mainstream given the use of NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures. Adopting CMS's recommended measures would enable benchmarking to other states that have done so, creating a mechanism to hold NYS's plan to a higher bar for quality.

- Leverages nationally recognized measures and surveys: CMS ratings rely on national standards including metrics from CMS NCQA HEDIS (referred to in documentation as "MLTSS metrics"), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and National Core Indicator (NCI). States have voluntarily been moving away from state-developed tools in favor of NCQA's HEDIS or NCI measures. For example, in a survey of 13 states with MLTSS, five states (including NYS) utilized state-developed tools to collect quality and members satisfaction data, whereas eight used HEDIS and/or NCI. While the carveout of nursing facilities from NYS's MLTCP program presents a challenge to holding plans accountable to certain measures, other states with such carveouts (e.g., Tennessee) are utilizing HEDIS for their MLTSS programs.
- More robust set of metrics: The UAS-NY CHA has more measures surrounding activities of daily living (ADL) than the CMS guidance requires. However, it misses some of the depth in experience of care, such as involvement in health decisions (beyond appointing) and overall life satisfaction. It also does not track certain preventative measures such as screening for falls, and it does not track process measures related to the service plan governing care. Incorporating CMS guidance would allow the state to track those domains. Given the nursing facility carveout, NYS's measure set deliberately excludes nursing facility measures; if NYS were to enact CMS measures, these would have to be excluded from that measure set as well.

Second, the quality measures are not up to date. NYS imposed a moratorium on community health assessments from March 2020 through July 2021 due to the COVID-19 pandemic. As a result, Consumer Guide ratings have not been updated since 2019 and the quality metrics section of the 2021 MLTC EQR report could not be completed. This is concerning because MLTC members are disproportionately affected by COVID-19. The importance of quality measurement has therefore only increased during this time, and out-of-date metrics limit the state's ability to hold plans accountable for improving quality.

Provider Access and Network Adequacy Measurement Gaps

There are two major issues underlying provider access gaps in MLTC: workforce challenges and limitations with existing network adequacy standards.

Workforce Challenges

Overall long-term care workforce shortages across the state result in access gaps for MLTC members.

In one study, 85% of NYS nursing home and assisted living facility operators reported difficulty recruiting for certified nursing aides, and 90% of NYS home health agencies reported difficulty recruiting for home health aides.[20]

A different report[21] found that NYS ranked 42nd in registered nurses (19 per 1,000 jobs) and 39th in nursing assistants (nine per 1,000 jobs). Conversely, NYS ranked first in home health and personal care aides (47 per 1,000 jobs), potentially due to growth in the Consumer Directed Personal Assistance

[20] Center for Health Workforce Studies "The Health Care Workforce in New York State: Trends in the Supply of and Demand for Health Care Workers," 2023, https://www.chwsny.org/wp-content/uploads/2023/05/Health-Care-Workforce-NYS-Trends-2023-Final.pdf.

[21] Jennifer L. Gaskin, et al., "2021 National Report on In-Home Care Affordability and Access," The Senior List, February 10, 2021; https://www.theseniorlist.com/research/caregiving-access-affordability-state-rankings/.

Program (CDPAP). Taken together, these figures indicate that while New Yorkers may have an easier time finding support for home health and activities of daily living, those with higher medical acuity likely face workforce challenges.

Benchmarking workforce to other states may yet hide challenges that persist in NYS's home-care workforce (including both medical and non-medical home care roles), particularly in unfilled positions, rising demand, and high turnover. These challenges all impact MLTC provider access.[22]

- Unfilled positions: 57% of home care positions are unfilled for 30+ days, and a shortage of >83,000 home care workers in NYS by 2025 is predicted.
- Rising demand: There is an estimated need for 27,000 new home care workers each year in NYS due to increasing demand.
- High turnover: There is an estimated need for 72,000 new home care workers annually in NYS to replace departing workers. Wages are likely a factor and further constrict access. One in four home care workers in NYS live below the poverty line and more than half rely on public assistance themselves. These obstacles pose challenges for home care workers in accessing reliable transportation and childcare and thus being able to consistently perform home care duties.

Limitations of Network Adequacy Standards

To evaluate provider access in MLTC, this report also assesses the current network of LHCSAs, which MCOs contract with to deliver home health services to MLTC members. Access to LHCSAs is critical to ensuring MLTC members can receive necessary long-term care. LHCSA access was the only measure of provider access in MLTC with data available to analyze for this report.

NYS's current MLTC network adequacy measures for LHCSAs include:[23]

- Maximum contracted LHCSAs per number of enrollees (1:100 for Downstate, 1:60 for Upstate).
- Minimum of two LHCSAs per county in a plan's service area.

There are currently over 600 LHCSAs in the state, and the capping of the number of contracted LHCSAs per plan was designed to limit further saturation of the LHCSA market. However, existing network adequacy standards for LHCSAs have three key limitations that make it challenging to evaluate accessibility of LHCSA services for members.

First, having an LHCSA under contract does not necessarily mean that the LHCSA is billing and therefore providing services. These standards do not account for such inactive, or "ghost," LHCSAs: 11% of MLTC Partial and 36% of MAP LHCSAs are ghost LHCSAs, meaning that while they are contracted with at least one MCO, they did not bill for a single Medicaid patient in any contracted plan over the 12-month period of claims data assessed. This indicates that contracting with an LHCSA does not necessarily equate to that LHCSA servicing members, constraining true provider access.

Second, the availability of a qualified home care worker, and third, whether that worker is close to a member's home (rather than the number of contracted LHCSAs) determines whether an MLTC member has access to services. However, data on the workforce of each LHCSA is not included as part of today's

[22] https://www.nysenate.gov/sites/default/files/article/attachment/long-term_care_workforce_hearing_report_2021.pdf.
[23] LHCSA Contract Limitation Guidance, New York State Department of Health, https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/lhsca_contract_guidance.htm.

MLTC adequacy standard. In June 2022, CMS recommended states consider measures such as staff to member ratios or the percentage of time that a care manager spends on direct services.[24] The recently proposed new rule on access and quality from CMS also proposes new measures focused on HCBS.[25] Additionally, NYS currently does not mandate time and distance standards between LHCSA contracted workers and members. For home care, travel time and distance largely affect the LHCSA workforce traveling to members. Large distances between the LHCSA workforce and enrollees may cause accessibility challenges, even if the overall number of workers improves.

Without specific workforce data per LHCSA, there is no assurance that the contracted LHCSA has a sufficient workforce with a particular skill set to provide timely, reliable access for members. This is a critical gap, particularly given known challenges in the home and personal care workforce in NYS and nationally. Specific opportunities for NYS to improve its network adequacy standards to address these challenges are covered in Section 12.

Conclusions

Overall, the MLTC market is fragmented, with too many market players and small plans. There is significant room for improvement in offering integrated Medicare and Medicaid plans to members; improving plan quality (especially Upstate); enhancing measurement of access and quality data; and simplifying administrative infrastructure for providers, plans, and the state. Since many of these challenges are tied to the number of plans offered overall and the number of low-enrollment plans in the market, giving the state a mechanism to select the optimal number of plans through a procurement is a potential key lever toward improvement

7 EVALUATION OF THE MAINSTREAM LINE OF BUSINESS

To evaluate the Mainstream line of business, this report:

- **Compares NYS's Mainstream market composition to peer states** to address the legislature's request for "a market assessment of the MCOs offering products in each market, including the appropriate number of managed care organizations to each region to address member needs."
- **Assesses current performance and challenges in the NYS Mainstream market** to address the legislature's request for an "analysis of areas of potential improvements or challenges…that may result from competitive procurement."

Given the >99% overlap in provider networks between Mainstream and HARP (as all HARP MCOs are Mainstream MCOs), assessments of provider experience, provider access, and behavioral health are covered for both Mainstream and HARP products in this section. HARP-specific challenges are covered in Section 8.

[24] CMS, "Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit," June 2022.
[25] CMS, "The Biden-Harris Administration Proposes New Standards to Help Ensure Access to Quality Health Care in Medicaid and CHIP," April 2023. https://www.cms.gov/newsroom/press-releases/biden-harris-administration-proposes-new-standards-help-ensure-access-quality-health-care-medicaid.

Comparison of NYS's Mainstream Market Composition to Peer States

This analysis evaluates the number of plans in the region and enrollment per plan across peers. Markets with a large number of plans and low enrollment per plan can be considered fragmented. For the list of plans in the NYS market and their respective enrollment, see Section 3.

As done for the MLTC market, this analysis benchmarks the market composition of NYC Metro against major cities within peer states. East/Central NY and West NY are analyzed together (as "Rest of NYS") against comparable exurban areas within peer states. As discussed in Section 5, the Mainstream peer states used in this report are California, Illinois, Maryland, Michigan, New Jersey, Ohio, and Pennsylvania.

Overall

Mainstream is NYS's largest line of business, covering over five million members or over 90% of total MMC enrollees. As of the writing of this report, NYS has 12 Mainstream MCOs. This is more plans than any benchmarked peer except California. Given large Mainstream Medicaid enrollment in NYS, enrollment per plan is relatively in line with peers.

NYC Metro

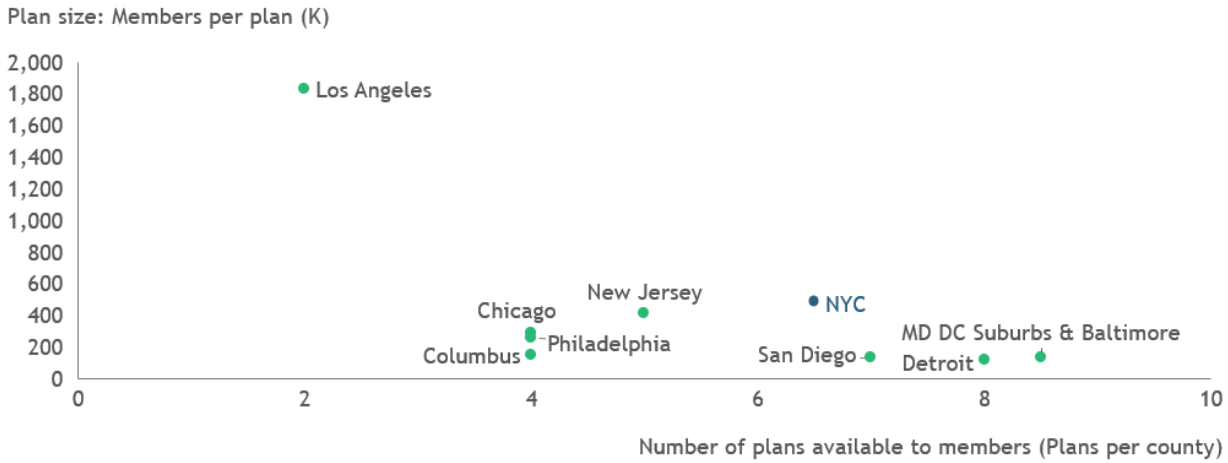
NYC Metro has eight plans overall. Members in the region on average can choose from approximately seven plans. There are 476,000 enrollees per plan on average, with a range of 71,000 to 1.3 million enrollees.

In contrast, other comparable regions have two to nine plans (both total plans in region and average plans per county available to members), with most peers having five or fewer plans. The size of those plans ranges from 124,000 members to 1.8 million members per plan. Los Angeles represents the upper bound of that range (1.8 million) and is the only peer metro that has a higher average plan size than NYS.

Accordingly, while NYS Metro has more plans than most peer regions assessed, the market is not necessarily fragmented because enrollment per plan is also high, and not all of those plans are available to every member.

A detailed benchmarking of peer regions is in the graph below.

Exhibit 7.1:	Mainstream Fragmentation Benchmarking—Major Metro Areas (Plan Size & Number of Plans)
Data source:	Benchmark State Enrollment Reports, Procurement Regions, and Census Data, Latest Month Available



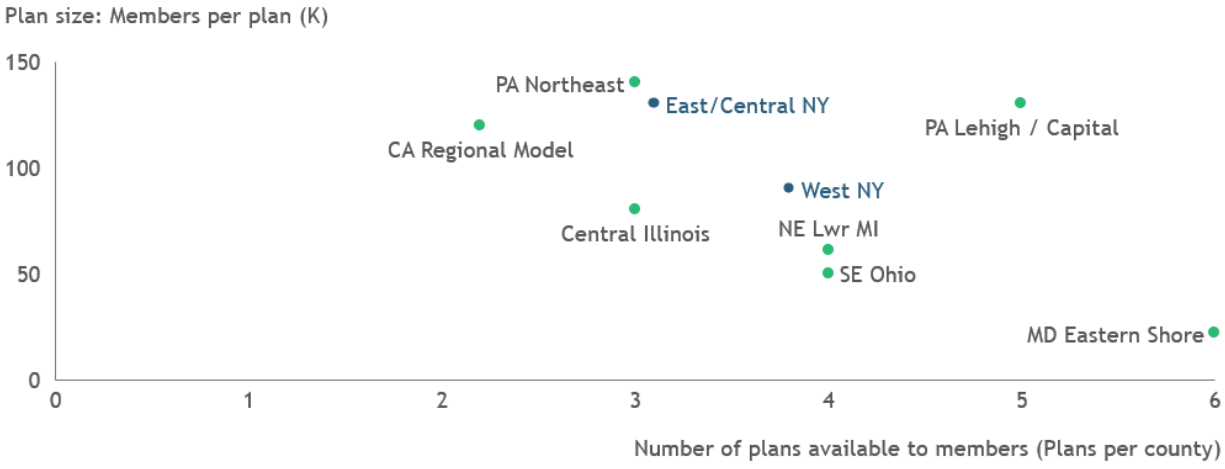
Rest of NYS

The rest of NYS also has eight plans overall, but plan choice is lower than in NYC Metro; Upstate members have an average of three to four plans available to them. There are ~100,000 members per plan on average, with a range of 4,000 to 607,000.

In comparison, peer regions have three to six plans, and members have an average of two to six plans available. There are 22,000 to 140,000 members per plan on average.

Therefore, the rest of NYS has more total plans than peer regions, but it falls in the middle of peers for plan choice and enrollment per plan. A detailed benchmarking of peer regions is in the graph below.

Exhibit 7.2:	Mainstream Fragmentation Benchmarking—Exurban Areas (Plan Size & Number of Plans)
Data source:	Benchmark State Enrollment Reports, Procurement Regions, and Census Data, Latest Month Available



Assessment of Current Performance and Challenges in the NYS Mainstream Market

The NYS Mainstream market outperforms peers in quality, administrative cost, and primary care access on average. However, several underperforming plans persist in the market. Furthermore, the large number of plans and presence of several small plans in the market contribute to challenges for members, providers, and the state. Most acutely, the market faces significant challenges in behavioral health.

Quality

Of the seven other peer states assessed in this analysis, NYS performs best overall on benchmarked quality measures.

A set of 13 representative HEDIS metrics (of the >90 measured by NCQA) was used to analyze and benchmark NYS Mainstream plans quality performance, summarized in the table below. The selection criteria and methodology are detailed in the appendix. For a specific definition of measures, please see the NCQA HEDIS website.[26]

The collector of this data, NCQA, prohibits publishing performance on individual metrics by state and by plan and only permits showing "proxy data" (non-identifying summary data). Therefore, the color-coding shown in the table below reflects the national percentiles reached by each state for that metric. Dark green signifies performance above the 90th percentile, light green signifies performance between the 75th and 90th percentile, yellow signifies performance between the 50th and 75th percentile, and red signifies performance below the 50th percentile. For example, on Plan All-Cause Readmissions, NYS performs between the 75th and 90th percentile, meaning that it is among the top 25% of performers nationally for this metric. If data was not available, the cell in the table is white and labeled "n/a."

As indicated at the bottom of the table, NYS outperforms peers on the 13 measures. NYS has:

- 10 measures above the 50th national percentile, versus three to eight for peers.
- Seven measures above the 75th percentile, versus zero to two for peers.
- One measure above the 90th percentile, which only one other state (MD) also achieves.

Exhibit 7.3:	Mainstream HEDIS Metrics; Performance Against National Percentile, NYS vs. Peer States
Data source:	NCQA Healthcare Effectiveness Data Information Set (HEDIS) quality metrics, 2021

Category	HEDIS Measure	NYS	PA	CA	OH	MD	NJ	MI	IL
Hospital	Plan All-Cause Readmissions (18s–64)								n/a
Children's Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
Children's Health	Well-Child Visits in the First 15 Months of Life (>5 visits)								
Maternity	Timeliness of Prenatal Care								
Primary Care	Asthma Medication Ratio								
Primary Care	Breast Cancer Screening								
Primary Care	Comprehensive Diabetes Care—HbA1c Control (<8%)								

[26] HEDIS Measures and Technical Resources, https://www.ncqa.org/hedis/measures/.

Primary Care	Controlling High Blood Pressure								
Primary Care	Statin Therapy for Patients with Diabetes—Statin Adherence 80%								
Mental Health	Follow-Up Care for Children Prescribed ADHD Medication						n/a		
Mental Health	Follow-Up After Hospitalization for Mental Illness—Seven-Day Rate	n/a		n/a		n/a		n/a	
Substance Use	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—Seven-Day Rate		n/a			n/a		n/a	
Substance Use	Pharmacotherapy for Opioid Use Disorder					n/a			
Total	**Measures above 50th percentile**	**10**	**8**	**7**	**6**	**5**	**5**	**4**	**3**
Total	**Measures above 75th percentile**	**7**	**2**	**2**	**0**	**2**	**2**	**2**	**0**
Total	**Measures above 90th percentile**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**

- Performance on metric above 90th national percentile
- Performance on metric between 75th and 90th national percentile
- Performance on metric between 50th and 75th national percentile
- Performance on metric below 50th national percentile
- n/a – Data not available

While NYS outperforms peers on these measures, it still has an opportunity to improve for two key reasons. First, statewide averages mask plan-level differences in performance. When performance on the measures is aggregated into a composite score by plan, there is a 16% spread between the highest- and lowest-performing NYS plan. This suggests there is still an opportunity to raise overall performance.

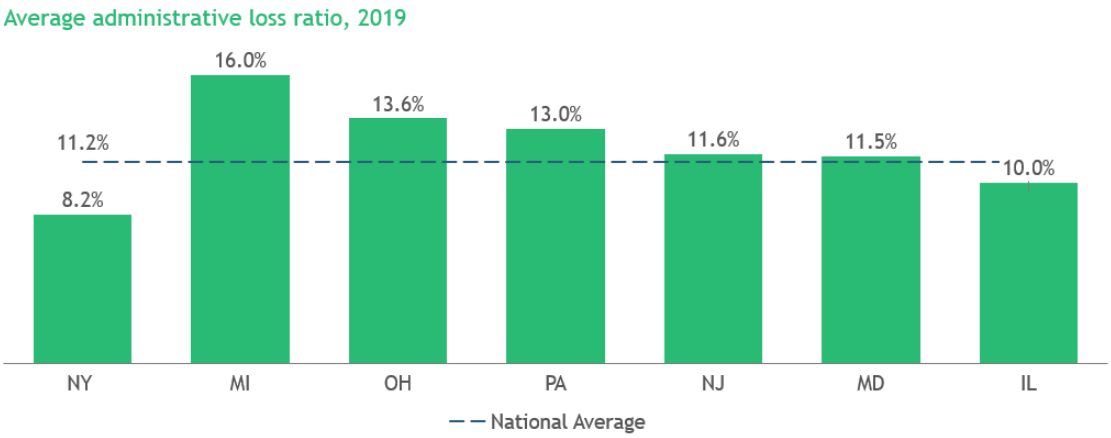
Second, for certain quality measures, national performance is poor, meaning that NYS can continue to strive higher than national benchmarks. For example, the national average for eligible members completing breast cancer screening is 51%, and the top 10% of plans nationwide only have 61% completion.

Administrative Costs

While data is available on administrative costs on a per-plan basis for NYS, it was not available for individual plans in other states. However, national averages and state averages were available in a report by Milliman, a leading actuarial firm that contracts with states to set managed care rates.

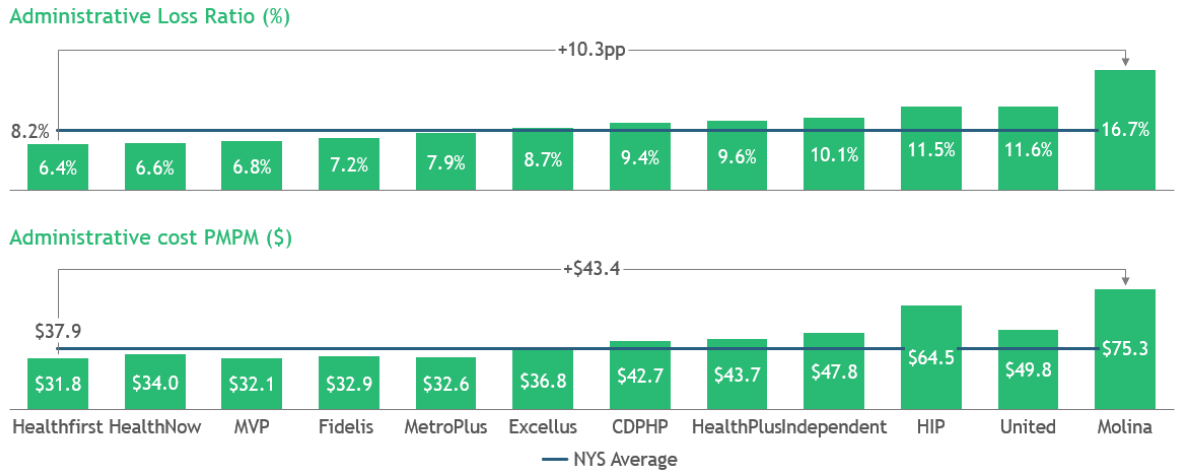
NYS's average administrative loss ratio (ALR) of 8.2% is below the national average (11.2%) and peers (10–16%). ALR is a measure of the amount of revenue spent on administrative versus medical costs by an insurance plan.

Exhibit 7.4:	Mainstream Administrative Loss Ratio, NYS vs. Peer States & National Average
Data source:	Milliman MMC Financial Results, 2019



As with quality, although NYS has lower average ALR than peers, there is still an opportunity to improve efficiency of certain plans. NYS plan-level ALR ranged from 6.4% to 16.7% in 2019. The 16.7% was a pre-merger outlier; after the 2021 acquisition of Affinity by Molina, the combined 2021 ALR was 13.9%, with correspondingly lower cost PMPM. However, this is still more than double the lowest ALR. Administrative cost challenges are explored further in the assessment of small plans.

Exhibit 7.5:	Mainstream Variation in ALR and Administrative Costs by Plan
Data source:	MCO Financial Reports, 2019



Primary Care Access

NYS has relatively strong primary care access based on primary care physician (PCP) activity in seeing Medicaid patients and plans' compliance with network adequacy standards. Ninety-one percent of PCPs (MD/DO only) across NYS Mainstream plans were found to be actively seeing Medicaid patients based on an analysis of 2021–2022 claims data. This is slightly higher than Kansas, Louisiana, Michigan, and Tennessee, which in a Health Affairs study showed an average of ~84% active adult PCPs and ~88% active pediatric PCPs.[27] Our analysis does not show how often Medicaid members see a PCP regularly, however.

[27] Avital B. Ludomirsky et al., "In Medicaid Managed Care Networks, Care Is Highly Concentrated Among a Small Percentage of Physicians," Health Affairs 41, no. 5, May 2022.

All counties are compliant with, and generally well below, NYS's maximum member-to-PCP ratio of 1,500:1.[28] However, these member-to-provider ratio standards assume PCPs are "full-time" (40 hours per week) with a single contracting plan, yet 80% of PCPs contract with three or more plans, and many also see non-Medicaid patients. This suggests that PCPs may not take on the full Medicaid member caseload presumed by the current standards, which may limit true PCP access for members. Potential improvements to network adequacy standards are explored in Section 12.

Member Experience

Member satisfaction in Mainstream according to national surveys (Consumer Assessment of Healthcare Providers and Systems, or CAHPS) is slightly below national averages by four to seven percentage points. The customer service rating score is the percentage of consumers responding "Usually" or "Always" to receiving needed information from and being treated with respect by their health plan's customer service. The health plan rating score reflects the percentage of consumers rating their experience with their health plan an 8, 9, or 10 out of 10. "Different methodology" indicates the state measures this metric differently than NYS, limiting comparability.

Exhibit 7.6:	Mainstream CAHPS, NYS vs. Peer States & National Average
Data source:	NYS MMC CAHPS 5.1H Adult Medicaid Survey Continuous Quality Improvement Report, April 2022. National average was given by a 2021 report from SPH Analytics, a vendor that conducts the CAHPS survey in many states. Peer states' statistics were retrieved from states' websites.

State	Customer Service Rating	Health Plan Rating
NYS Maximum	91%	81%
NYS Minimum	81%	69%
NYS Average	86%	73%
National Average	90%	80%
Michigan Average	89%	Different methodology
California Average	88%	75%
Maryland Average	88%	Different methodology
New Jersey Average	88%	79%
Illinois Average	87%	Different methodology

As shown in the table below, the gap between the highest- and lowest-performing NYS plans in member satisfaction surveys is up to 12 percentage points. Five plans are 10 to 11 percentage points below the national average.

Exhibit 7.7:	Mainstream CAHPS Scores by Plan
Data source:	NYS MMC CAHPS 5.1H Adult Medicaid Survey Continuous Quality Improvement Report, April 2022

[28] Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (rev. March 1, 2019), New York State Department of Health, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf; Sec. 21.12.

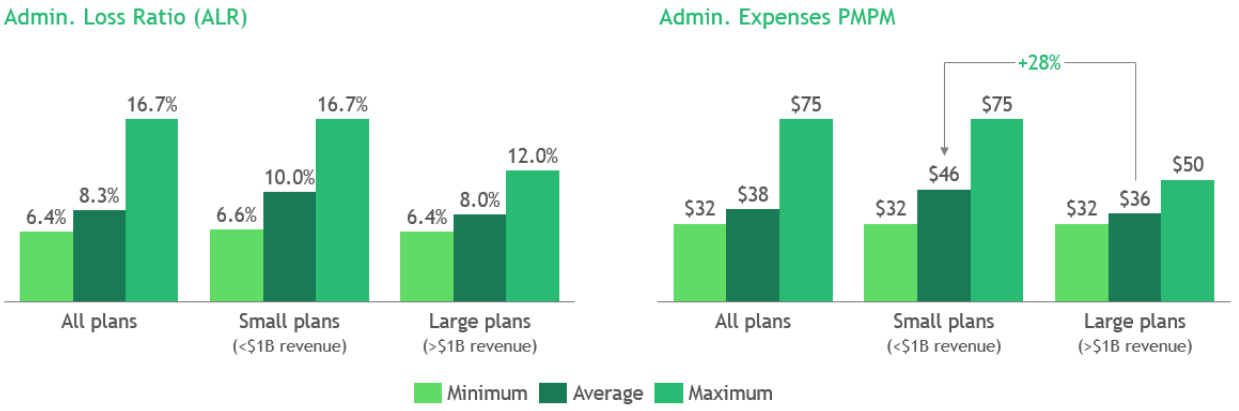
Plan Name	Customer Service Rating	Health Plan Rating
National Average	*90%*	*80%*
Affinity	91%	70%
MVP	90%	75%
United	90%	69%
Excellus	90%	81%
Independent	89%	81%
HealthNow	88%	74%
Fidelis	85%	74%
MetroPlus	85%	69%
CDPHP	84%	78%
Healthplus	84%	74%
HIP	83%	70%
Molina	82%	69%
Healthfirst	81%	73%

Small Plans

Of the 12 Mainstream plans in NYS, seven have less than $1 billion in annual Mainstream revenue (considered a small Mainstream plan in this report). As in the MLTC market, small Mainstream plans underperform large ones in several key areas:

- Administrative cost: Smaller Mainstream plans within NYS average 28% higher per-member administrative costs. A chart showing the difference between large and small plans' cost is below.

Exhibit 7.8:	Mainstream Administrative Costs by Plan Size
Data source:	MCO Financial Reports, 2019



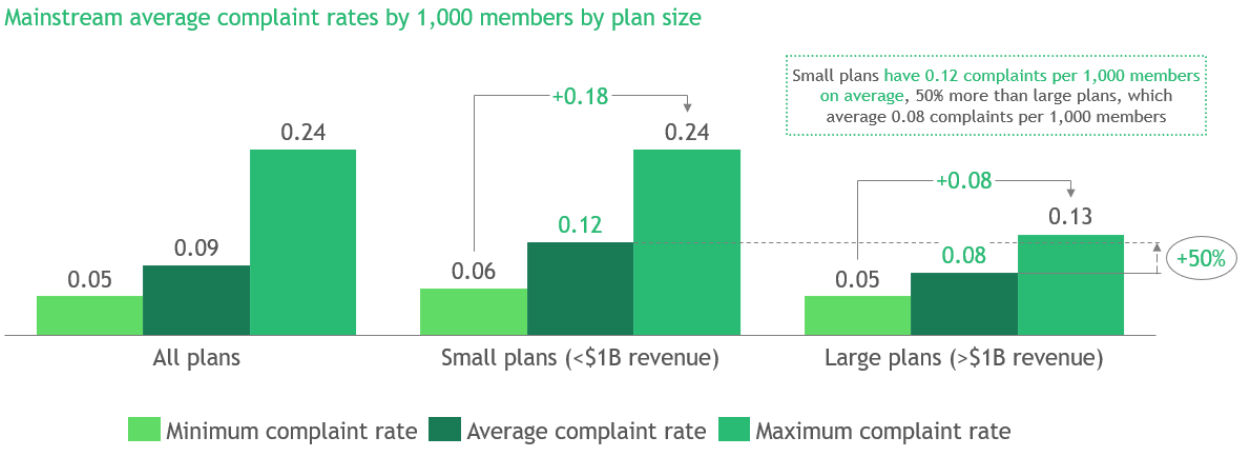
- Profitability: Of 15 Mainstream plans present in the market in 2019, two of six large plans were unprofitable, whereas seven of nine small plans were unprofitable. (Note: 15 plans were in the market in 2019. Three plans were acquired by other players between 2020 and 2021, leaving 12 remaining plans). Furthermore, profitability varies more significantly among small plans. The spread in losses between the two unprofitable large plans was ~$14 PMPM (ranging from ~$3 to ~$17 PMPM), while the spread among small plan losses was ~$32PMPM (ranging from ~$4 to $36 PMPM.

Exhibit 7.9:	Mainstream Administrative Costs & Profitability
Data source:	MCO Financial Reports, 2019

Plan Name	Member Months	Revenue PMPM	Admin Costs	ALR	Premium Income Profit (Loss)	Plan Size
Fidelis Care	14,749,51	$459	$33	7.20%	$22.15	Large
HealthFirst PHSP, Inc.	11,114,02	$494	$32	6.40%	($3.45)	Large
United Healthcare Plan of NY	5,179,038	$431	$50	12%	($17.04)	Large
MetroPlus Health Plan	4,313,975	$410	$33	7.90%	$0.38	Large
Healthplus	3,729,867	$456	$44	9.60%	$8.67	Large
Affinity Health Plan	2,331,203	$444	$38	8.60%	$1.12	Large
Excellus Health Plan	2,008,840	$425	$37	8.70%	($14.52)	Small
MVP Health Plan, Inc.	1,923,590	$473	$32	6.80%	($8.81)	Small
HIP	1,493,963	$559	$64	11.50%	($12.86)	Small
WellCare of New York, Inc.	1,253,317	$407	$60	15%	$10.97	Small
Capital District Physicians Health Plan	957,517	$454	$43	9.40%	($13.40)	Small
Independent Health Association, Inc.	658,430	$475	$48	10.10%	($15.84)	Small
YourCare Health Plan	442,816	$462	$45	10%	($36.38)	Small
HealthNow	418,084	$518	$34	6.60%	($4.41)	Small
Molina Healthcare of NY	320,613	$450	$75	16.70%	$17.77	Small

- Member complaints: Small plans had 50% higher complaint rates in 2021 on average than large plans (0.12 complaints per 1,000 members versus 0.08 complaints per 1,000 members). Furthermore, small plans have a higher range of member complaint rates than large plans. The highest complaint rate among small plans is nearly double that of the highest complaint rate among large plans (0.24 versus 0.13 complaints per 1,000 members, respectively).

Exhibit 7.10:	Mainstream Member Complaint Rate by Plan Size
Data source:	BCS Member Complaints, 2021



Large Number of Plans

NYS has more total Mainstream plans than all but one benchmarked peer (California). As in the MLTC market, this poses challenges:

- Provider experience: Having more plans in the market increases provider burden, as each plan has its own administrative processes. In Mainstream and HARP (analyzed together, given overlapping provider networks), nearly a third of providers (29%) contract with five or more plans. This is more plans than most benchmark states have in total. This provider burden is consistent across NYS regions; the percentage of providers contracting with five or more plans is 24% in East/Central NY, 28% in West NY, and 31% in NYC Metro.

Exhibit 7.10:	Mainstream & HARP Contracting Burden of Providers (Number of Contracted Plans by Percentage of Providers)
Data source:	NYS Provider Network Data System (PNDS), 2023

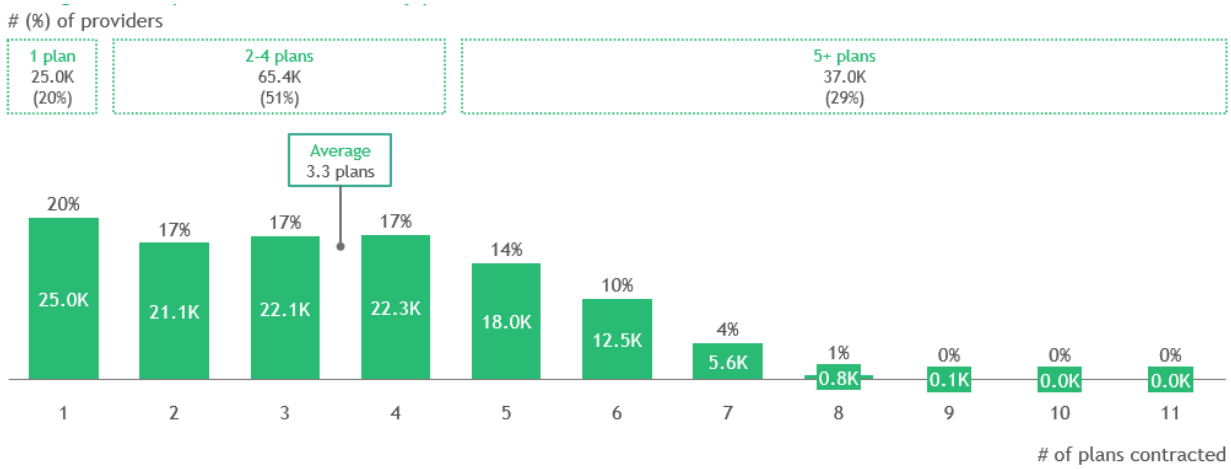
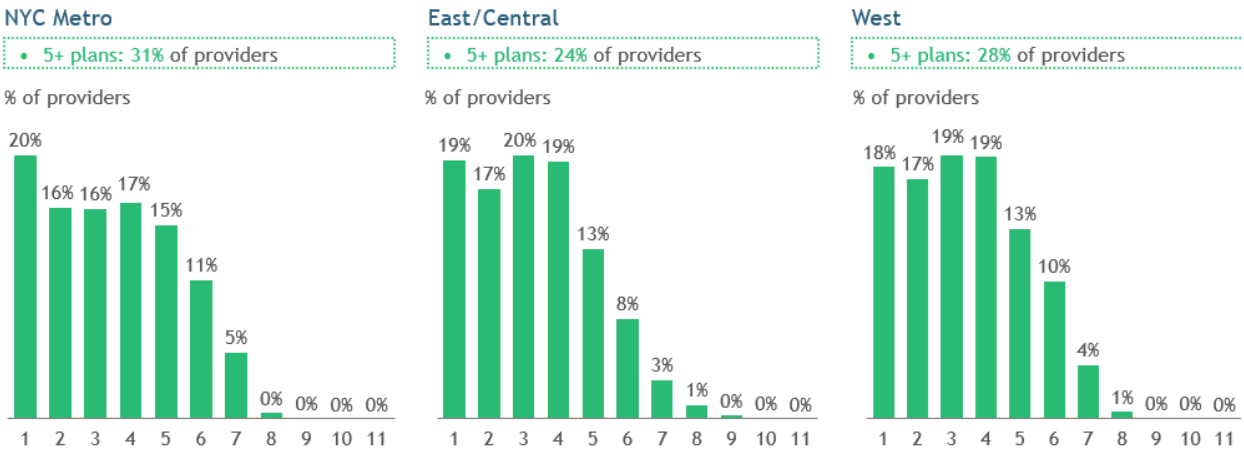


Exhibit 7.11:	Mainstream & HARP Contracting Burden of Providers by Region (Number of Contracted Plans by Percentage of Providers)
Data source:	NYS Provider Network Data System (PNDS), 2023



- State oversight: With fewer plans to oversee, OHIP could better engage in active contract management to improve plan performance on all program goals. OHIP would also be better

equipped to sanction Mainstream plans that do not meet contractual standards if necessary. Contract management is explored further in Section 12.

Behavioral Health

NYS is one of 30 states (of 41 with MMC) that carve behavioral health into MMC.[29] NYS has structured its Mainstream program to provide integrated physical and behavioral health coverage, meaning physical and behavioral health benefits are covered by the same MCO.

The Mainstream market is confronting acute challenges in BH care delivery. The shortage of BH providers is a national challenge and not solely in the purview of NYS managed care to solve. Merely strengthening BH network adequacy rules alone will likely not significantly increase BH access for members because the MCOs cannot create new supply where it does not exist. However, NYS sets BH network adequacy standards for Mainstream and HARP to ensure a minimum level of access for members, within the constraints of existing supply.

Plans do not meet the requirements set in the contract today for network adequacy. Mainstream and HARP MCOs are generally required to contract with two facilities per county in urban areas and two per RPC region in rural areas. If MCOs cannot meet this standard due to lack of provider supply, then MCOs can meet their network adequacy requirement by contracting with surrounding county providers.

Moreover, large gaps are found when evaluating providers' activity in treating Medicaid patients; many providers in a network are so-called "ghost providers." Meanwhile, MCOs have been underspending on BH services and not materially engaging in efforts to improve access or quality of care.

These challenges are detailed below. Given the overlap in the Mainstream and HARP provider networks, these issues apply to both lines of business.

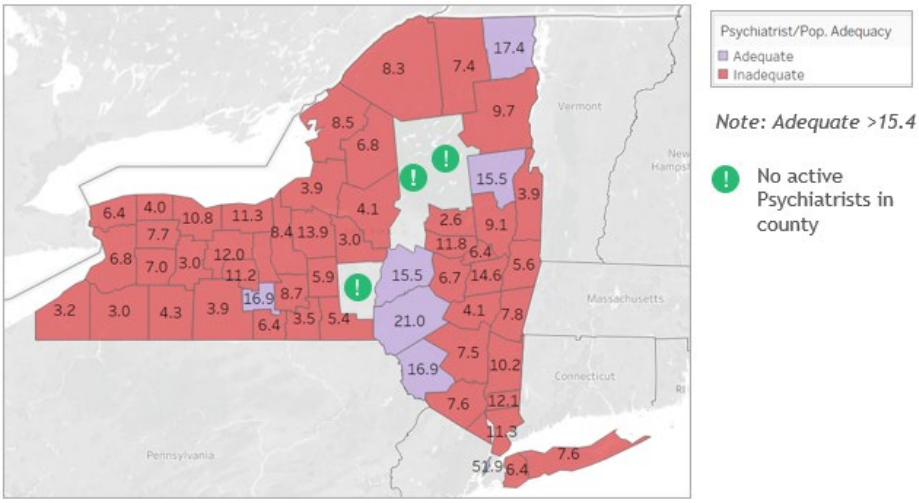
- Network deficiencies and inactive providers: Three analyses demonstrate deficiencies in the Mainstream/HARP behavioral health provider network:
    - **Noncompliance with psychiatrist ratios:** Averaged by plan, 88% of counties fail to meet NYS's adequacy standard for psychiatrists (15.4 per 100,000 population).[30] Furthermore, NYS meets just 19% of needs for psychiatrists. This is below the national average of 28%, creating Health Professional Shortage Areas (HPSA).[31] Widescale noncompliance with this standard constrains members' ability to receive adequate and timely psychiatric care.

Exhibit 7.12:	Active Psychiatrists per 100K Total Population by County
Data source:	PNDS, 2023

[29] Madeline Guth, "How Do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs," May 25, 2023. Kaiser Family Foundation. https://www.kff.org/report-section/how-do-states-deliver-administer-and-integrate-behavioral-health-care-findings-from-a-survey-of-state-medicaid-programs-appendix/ (Note: Statistic as of 7/1/2022).

[30] Based on all psychiatrists contracted across Mainstream/HARP plans in county, divided by county population. Treats NYC as one county due to enrollment data limitations.

[31] "Mental Health in New York," KFF, https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/new-york/.



- **Noncompliance with BH network adequacy standards:** Analysis from the Office of Mental Health (OMH) indicates that 14% of BH service networks are deficient across plans. A "deficiency" is defined as any instance of a plan failing to meet one of the 17 BH network contracting standards. In general, the standard is that plans must have at least two providers of a service in the county for urban counties or in a Regional Planning Consortium (RPC) region for rural counties. Compliance with these standards may underestimate access challenges members face, particularly in rural counties. For example, one plan is considered compliant for the Assertive Community Treatment (ACT) service in St. Lawrence County because there are at least two providers in the Utica-Adirondack RPC region. However, there are no ACT providers in the county, and the nearest contracted provider is up to a three-hour drive away in Oneida county. Plans are required to arrange for out-of-network services if in-network is not available, but there is still opportunity to improve existing standards in rural areas. If current standards were raised to require rural counties to have two BH service providers per county rather than RPC region, our analysis indicates that 24% of networks would be deficient, a 10-percentage-point increase from OMH's analysis. The output of our independent analysis is detailed in the table below.

Exhibit 7.13:	BH Service Network Deficiencies for Mainstream & HARP Plans
Data source:	BH PNDS Network Reporting Data, Q4 2022

Below average

Plan	Inadequate Networks (Deficiencies)		Adequate Networks		Total
	Count	% of total	Count	% of total	
EXCELLUS	92	49%	95	51%	187
CDPHP	127	47%	145	53%	272
HEALTHNOW	17	30%	39	70%	56
UNITED	242	30%	557	70%	799
HEALTHPLUS	37	28%	96	72%	133
EMBLEM (HIP)	23	17%	113	83%	136
FIDELIS	182	17%	872	83%	1054
MOLINA	46	15%	260	85%	306
MVP	53	15%	304	85%	357
IHA (Independent)	2	12%	15	88%	17
HEALTHFIRST	16	9%	154	91%	170
METROPLUS	5	6%	80	94%	85
Total	**842**	**24%**	**2,730**	**76%**	**3,572**

    - **Inactive providers:** Even when BH network adequacy standards are met, members may still face access challenges if BH providers are not actively treating Medicaid patients. In an analysis of 2021–2022 claims data, only 57% of all BH providers billed for at least one Medicaid patient in at least one contracted plan that year—a low bar for access. In other words, up to 43% of the BH network may consist of "ghost" providers, a considerably larger percentage of ghosts than among PCPs (9%). This stark gap for BH providers is consistent with the Health Affairs study, which found that psychiatrists were the most likely to qualify as ghost physicians (~36% of psychiatrists versus ~16% of all physician types assessed).[32] Provider inactivity demonstrates that network adequacy standards stipulating the number of contracted providers are necessary but insufficient to ensure access for members. This is explored further in Section 12.
- Noncompliance with MHPAEA: The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law designed to ensure fair and adequate access to BH services. NYS issued MCOs 95 citations for noncompliance from 2018 to 2020.[33] A 2022 survey of MCO documents found that several MCOs repeatedly failed to demonstrate compliance.[34] These violations raise further concern about BH access for members.
- MCO underspending on BH services: Even with insufficient provider networks, MCOs are not spending all their allotted premiums on BH services. A review of two MCO funding mechanisms for BH—the Behavioral Health Expenditure Target (BHET) and Medical Loss Ratio (MLR) recoveries—shows that MCOs remitted over $220 million in allocated premiums back to the state from 2017 to 2020. This includes $91 million in BHET remittances from 2018 to 2020 and $130 million in MLR remittances from 2017 to 2019.[35]
- Inappropriate claims denials for BH specialty services: OMH reviews of BH claims reports submitted by MCOs have found high levels of inappropriate claims denials for BH specialty services. Based on MCO reported claims data from December 2017 to May 2018, OMH estimates there were $39 million worth of claims denials for BH specialty services. OMH investigated the reasons for the inappropriate level of claims denials and issued 20 official citations to certain MCOs. Citations were issued for failure to properly oversee the MCO's BH

[32] Avital B. Ludomirsky et al., "In Medicaid Managed Care Networks, Care Is Highly Concentrated Among a Small Percentage of Physicians," Health Affairs 41, No. 5, May 2022, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01747?journalCode=hlthaff.
[33] New York State Office of Mental Health, internal documentation provided February 2023.
[34] Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report: New York Medicaid Managed Care, Alternative Benefit Plan, and Children's Health Insurance Program, NYS OMH, OASAS, DOH, March 14, 2022, https://www.health.ny.gov/health_care/managed_care/reports/docs/compliance_report_3-22.pdf.
[35] New York State Office of Mental Health, internal documentation provided February 2023.

vendor (Beacon) and failure to reimburse specialty BH providers at mandated government rates. OMH issued a Cash Advance directive that instructed MCOs with denials above state-set thresholds to reach out to affected providers to negotiate a settlement amount for inappropriately denied claims. The estimated dollar value ultimately reprocessed and paid by MCOs for these claims in response to NYS action was $11.6 million. However, even with this action by OMH, affected BH specialty providers experienced delays in receiving payment. DOH and OMH issued citations and conducted targeted surveys in response to this issue, significantly reducing inappropriate claims denials. Similar root-cause analysis of claims data from April 2021 through September 2021 found an estimated $11.5 million in claims denials, a ~60% reduction.

- Limited MCO innovation and engagement in improvement efforts: MCOs have shown little innovation to improve upon workforce challenges. Additionally, there have been no applications for in-lieu-of services (i.e., medically appropriate, cost-effective substitutes to a covered service), despite this being an option available to plans.[36] Furthermore, OMH has struggled to entice MCO participation in quality-improvement initiatives. According to stakeholder interviews, OMH tried to engage MCOs in Critical Time Intervention for high-need BH populations but did not secure participation, even with a $400 incentive per member engagement visit. Likewise, stakeholder interviews indicate that MCOs did not participate in an OMH-led Performance Opportunity Project to increase adoption of evidence-based practices for high-risk/high-need populations. Lastly, despite network requirements, managed care has relied on additional government funding to bring inpatient psychiatric beds online.

Conclusions

Of the NYS Mainstream market's many plans, several are low-performing. Increasing competition or selecting the best plans could improve the market. BH access is deficient across the market, meaning selecting the best-performing plans may be helpful but is unlikely to be sufficient to resolve BH challenges, particularly given these issues are in the context of national BH challenges. BH funding has been returned from plans to the state, demonstrating that plans have not used all available financial resources to improve BH care delivery. NYS can address these challenges by improving product design, increasing competition among plans, investing in BH workforce development, and raising and enforcing contract standards.

[36] Ibid.

8 EVALUATION OF THE HARP LINE OF BUSINESS

To evaluate the HARP line of business, this report:

- Provides background on the NYS HARP model, including an overview of its structure and goals, how its product design compares to other state models, the market landscape, and the member journey from enrollment to receiving services.
- Assesses current performance and challenges in the NYS HARP market, to cover the legislature's request for an "analysis of areas of potential improvements or challenges…that may result from competitive procurement."

Background

Overview and Goals of HARP

Health and Recovery Plans (HARPs) provide Medicaid coverage and specialized services for those with serious mental illness (SMI) or substance-use disorder (SUD). In addition to the same physical and behavioral health coverage as Mainstream plans, HARPs offer enhanced care management and access to an expanded benefit package of behavioral health (BH) home- and community-based services (HCBS) and community-oriented recovery and empowerment (CORE) services. HARPs also have requirements around staffing qualifications for adequate provision of care.

NYS introduced the HARP product in 2015 as part of a broader BH transition from fee-for-service to managed care. Behavioral health was integrated to develop improved mental health services that were person-centered, recovery-oriented, data-driven, and evidence-based. The goal of HARP specifically was to address rising rates of substance abuse and mental illness, increasingly poor outcomes (e.g., readmission rates for those with severe BH needs), growing costs of fee-for-service health care, and an escalating need for more integrated and comprehensive care. Creating a dedicated product line was intended to provide specialized care and enable heightened focus on this small but high-need population, so that these members would not get lost in the broader Mainstream managed care population.

HARP Product Design Compared to Other States

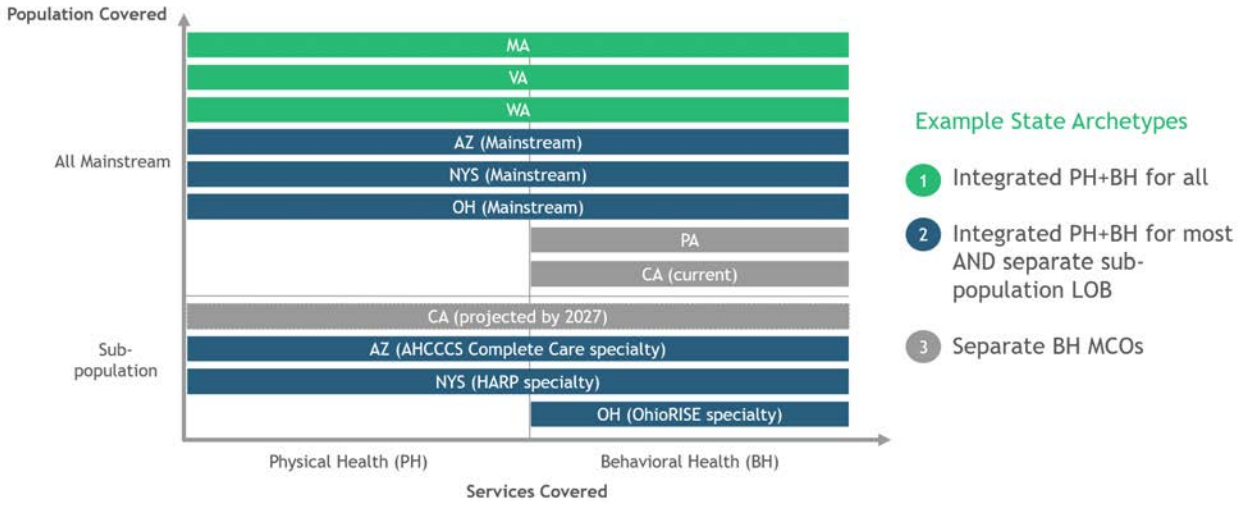
While 30 states carve BH into managed care to some extent, states make different decisions on which populations and services to cover, resulting in many unique models. For example, states may design a BH product for a specific sub-population based on age and/or diagnosis. Alternatively, states may decide to cover all populations, regardless of BH needs, with their Mainstream product. For services, states can determine whether their Mainstream and/or their dedicated BH product provide integrated physical and behavioral health (i.e., both provided by the same MCO), or if the BH specialty MCOs only provide BH and members receive their physical health coverage from a separate MCO.

NYS HARP plans cover an age and diagnosis-based sub-population (adult SMI/SUD) while Mainstream plans cover the general population. Both HARP and Mainstream plans provide integrated physical and behavioral health coverage to members. In comparison, some states, such as Washington, Massachusetts, and Virginia, provide integrated physical and behavioral health coverage for all

populations within the Mainstream line of business. Other states, such as Pennsylvania, have separate behavioral health MCOs for all populations, with physical health benefits covered by a different MCO. Some states have separate behavioral health MCOs only for select populations but integrated physical and behavioral health coverage for the Mainstream population. For example, Ohio has a specialty BH product for youth (OhioRISE) and Arizona has a specialty BH product for members with SMI, while both states also have integrated physical and behavioral health coverage in Mainstream.

These state approaches are shown in the figure below.

Exhibit 8.1:	BH Program Design Benchmarking
Data source:	Peer State Websites, Latest Available



HARP Market, Enrollment, and Service Delivery

11 MCOs offer HARP plans as of the writing of this report. These MCOs all also offer Mainstream plans. The 12th and final Mainstream MCO is expected to add HARP enrollment in the coming year. The alignment of Mainstream and HARP MCOs was an intentional design choice by the state to ensure continuity of care and seamless transitions across the two products as members' needs evolve.

Eligibility for HARP is determined by NYS based on past utilization of Medicaid services indicating SMI or SUD. After eligibility is determined, a member is automatically ("passively") enrolled in a HARP plan with the same MCO that provided them Mainstream coverage. Newly eligible HARP members receive notification of enrollment by mail and have a 30-day window to opt out, after which they are formally enrolled into HARP. The member then has 90 days to either change HARP plans or leave HARP (and return to their Mainstream Medicaid plan). There are nearly 170,000 HARP enrollees as of July 2022, and 85% of HARP-eligible Medicaid members are enrolled in HARP.[37]

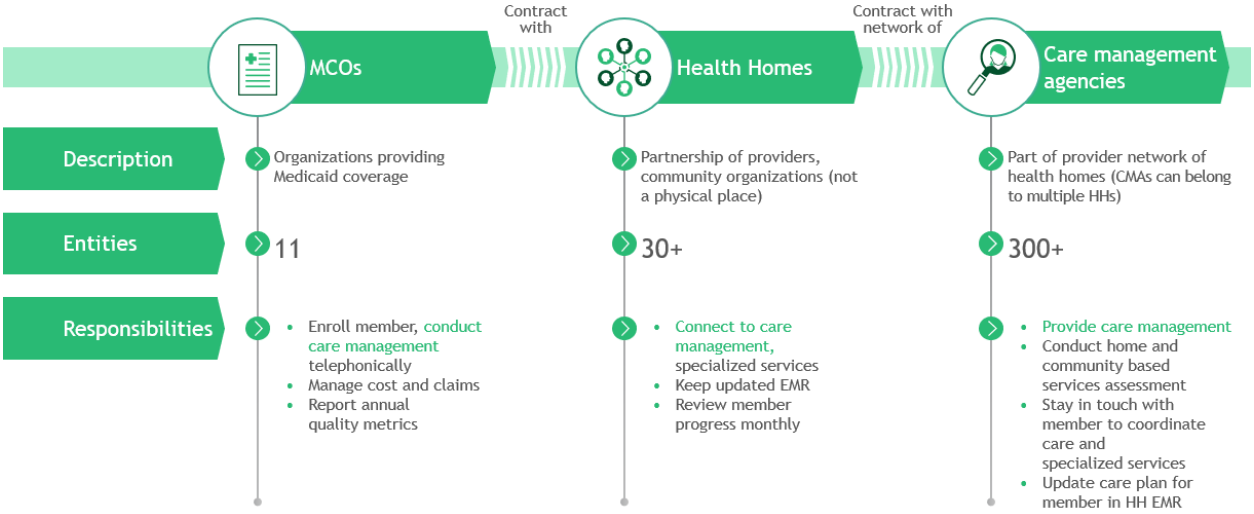
Specialized HCBS and CORE services that differentiate HARP include crisis and medical recovery support tailored to SMI/SUD populations as well as broader support through housing assistance, job assistance,

[37] Ibid.

and other social initiatives. These services are primarily facilitated through Health Homes and delivered by CORE and HCBS providers.

Health Homes are partnerships of providers and community organizations who contract with care-management agencies to provide care coordination and help members access the specialized services they qualify for. Health Homes were created by the Affordable Care Act (ACA) as a mechanism for states to encourage whole-person care and care coordination outside MMC. MCOs contract with a subset of 30 Health Homes in NYS,[38] who in turn contract with a subset of about 300 care management agencies. Care management agencies conduct assessments required for HCBS and update member care plans in the electronic medical record (EMR) of the Health Home.

Exhibit 8.2:	Overview of Key Entities in HARP Model
Data source:	NYS DOH Website

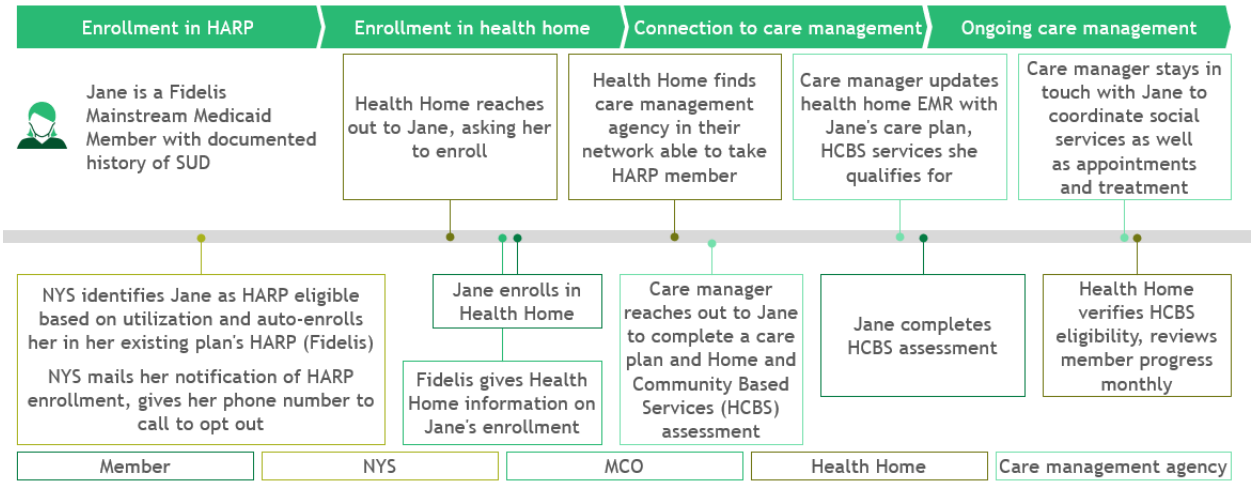


For the model to work effectively, HARP service delivery requires a high degree of collaboration between MCOs, Health Homes, and care-management agencies. It also requires high member engagement. Members must navigate a multi-step process to receive specialized HCBS/CORE services, as demonstrated in the illustrative graph below.

Exhibit 8.3:	Illustrative Example of HARP Member Journey
Data source:	Advocate resources[39] and stakeholder interviews

[38] "Medicaid Health Homes—Comprehensive Care Management," NYS Department of Health, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/.

[39] "How to Get Services in the Home or Community (BH HCBS) through Medicaid HARP," Urban Justice Center, https://mhp.urbanjustice.org/wp-content/uploads/sites/10/2020/05/How-to-Get-HARP-Services-BH-HCBS-Workflow-Final-2020.05.06-.pdf; "Options for Enhancing New York's Health Home Initiative: A Discussion Paper," Citizens' Budget Commission, https://cbcny.org/research/options-enhancing-new-yorks-health-home-initiative.



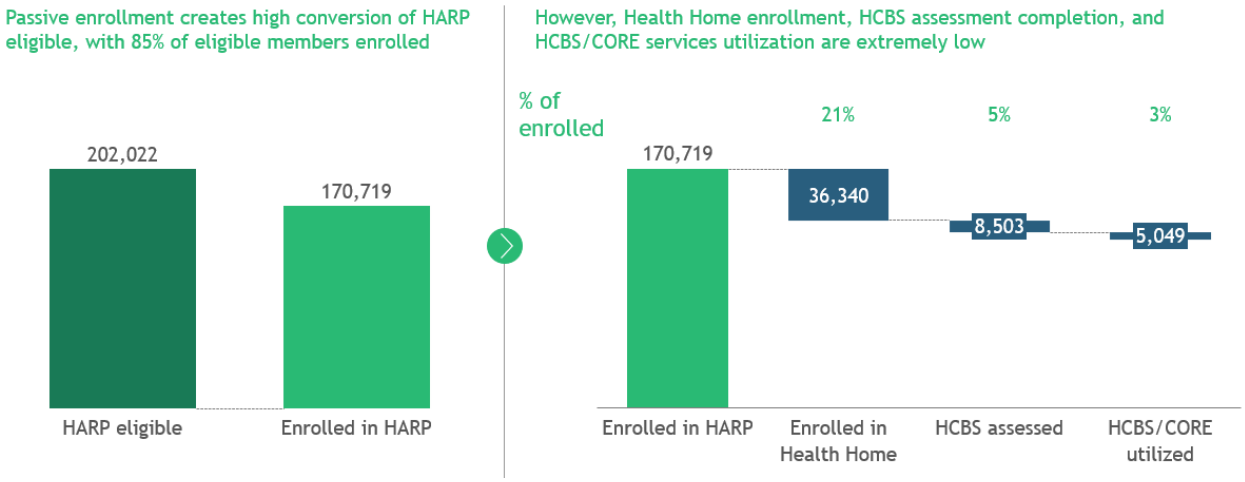
Assessment of Current Performance and Challenges in the NYS HARP Market

The HARP model has successfully enrolled the majority of eligible members with high-acuity BH needs into specialty HARP plans, as intended by its product design. However, it has not yet improved BH provider access, utilization, or outcomes.

- BH provider access gaps: Given the >99% overlap in the provider networks between Mainstream and HARP plans, the provider access gaps discussed in Mainstream also plague HARP. The impact of these gaps is magnified in HARP since it is designed to serve high-acuity members with SMI/SUD.
- Low utilization of specialized services and care management: In theory, access to Health Homes and specialized HCBS and CORE services is meant to differentiate the HARP service offering from Mainstream. However, only 21% of HARP members are enrolled in a Health Home and only 3% of members utilized HCBS or CORE services in the past year.[40] NYS has attempted to increase access to these services to improve utilization. For example, in February 2022, the state transitioned a subset of the original BH HCBS services into CORE services, which have lower administrative barriers to qualify for and receive services (e.g., no HCBS assessment or plan of care approval needed). The majority of utilization of HCBS/CORE services is now driven by CORE services. The state also introduced the Health Home Plus model for SMI, with higher reimbursement rates for the highest-acuity individuals in HARP. Despite these changes, utilization remains low.

Exhibit 8.4:	Funnel: HARP Eligibility vs. Service Utilization by Process Step
Data source:	OMH HARP Data, Feb. '22–Feb. '23, except HCBS assessment, which is Oct. '21–Oct. '22

[40] New York State Medicaid Adult BH HCBS/CORE Access Dashboard, Medicaid Data Warehouse, February 2023.



- Limited outcomes improvement: HARP program implementation has not resulted in meaningful improvement of quality-of-care measures related to mental health services. From 2015/2016 through 2020, HARPs demonstrated no change in performance on key measures such as seven- and 30-day follow-up after a hospitalization or ED visit and potentially preventable readmissions for mental health. Moreover, NYS DOH contracted with the RAND Corporation to complete an independent evaluation of whether the HARP program achieved its goals, including improving BH outcomes. The study found there was not strong evidence to support that HARP improved quality of care measures from 2016 to 2019 relative to a baseline FFS population. The study considered HEDIS measures and prevention of BH conditions. However, the study did show that HARP likely improved access in some important dimensions, including access to Health Homes care coordination.[41]

These challenges exist within a broader context of pervasive issues in BH care delivery nationwide, both within and outside Medicaid managed care.

In recent years, these issues have been compounded by COVID-19, ongoing BH workforce shortages, and increasing demand. For example, a recent study of Oregon published in *Health Affairs* found that despite being one of eight states with a Medicaid reimbursement rate that is on par or greater than Medicare for mental health services, the state consistently ranks among the worst states for access to mental health services. Access is constrained by high demand, workforce shortages, and provider administrative burden.[42]

However, NYS has made certain product decisions for HARP that have contributed to the program's shortcomings:

- Undifferentiated MCOs in HARP model: NYS designed HARP to ensure continuity of care and seamless transitions with Mainstream MCOs. As a result, members can choose from a large number of HARP plans. An alternative approach would have been to use procurement to select the best MCO to specialize in BH, offering the highest quality experience for BH members with the largest BH provider network. While other states have likewise created specialty BH MMC

[41] Horvitz-Lennon et al. "Independent Evaluation of the New York State Health and Recovery Plans (HARP) Program," Rand Corporation, 2022, https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/harp_interim_eval.pdf.

[42] Jane M. Zhu et al. "Medicaid Reimbursement for Psychiatric Services: Comparisons Across States and With Medicare," Health Affairs 42, No. 4, April 2023, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00805.

products (e.g., Ohio, Arizona, Pennsylvania), this report has not identified another state that did not constrain the number of participating MCOs. For example, Ohio ran a procurement to select a single high-quality plan for its specialty youth BH product.

- Overlapping roles and responsibilities across stakeholders: Several disparate stakeholders (MCOs, Health Homes, care management agencies, CCBHCs, and providers) have overlapping roles and responsibilities, particularly for care management. This blurs the lines of accountability and results in duplicative care management expense. Care managers play a pivotal role in directing members with BH needs to care. For example, the Substance Abuse and Mental Health Services Administration has found that one third of adults aged 18 or older in the U.S. who reported having a mental illness and an unmet need for services indicated that they did not receive care because they did not know where to go for services.[43] Overlapping care management roles in NYS's HARP program may be a contributor to HARP members' low utilization of HCBS/CORE services by potentially causing confusion or impeding access for individuals with SMI/SUD, who already face stigmatization, barriers to care, elaborate treatment regimens, and challenging social needs.[44] NYS can consider revisiting roles and responsibilities in this model in a person-centered manner based on who is best positioned and trusted to engage patients.
- Ineffective incentives in the Health Home model: According to stakeholder interviews, MCOs may not be sufficiently incentivized to engage in the Health Home model. During NYS's Delivery System Reform Incentive Payment (DSRIP) Program, the state emphasized and incentivized care management through the patient-centered medical home (PCMH) primary care model. While well-intentioned, this focus may have inadvertently lowered incentives to engage in the Health Home care management model that was meant to be the backbone of HARP. Furthermore, given reimbursement is based on continued member engagement, Health Homes are incentivized to engage mild to moderate members over high-acuity members, who can be difficult to engage consistently. The Health Home Plus model, with higher reimbursement rates for those with the most severe BH needs, was introduced to address this shortfall, yet uptake and impact of the Health Home Plus model has been limited. NYS can look for ways to better scale the Health Home Plus model and track utilization more actively.

Conclusions

NYS is an outlier in creating a specialty BH product that is distinct from its Mainstream product but has the same set of MCOs and same care management model. HARP MCOs face similar issues as they do in the Mainstream market. The current care management model is impaired by blurred lines of accountability across entities and flawed incentives. A procurement—whether for HARP only or for Mainstream and HARP jointly—could help improve BH access, utilization, and outcomes by enabling NYS to select the plans that are best equipped to provide integrated physical and behavioral health for members with high-acuity BH needs. NYS can also consider redesigning its care management model. Improving BH broadly is explored further in the next section.

[43] Hemangi Modi, Kendal Orgera, Atul Grover, "Exploring Barriers to Mental care in the U.S.," AAMC, October 10, 2022, https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care.

[44] Nicholas C. Coombs, Wyatt E. Meriwether, James Caringi, Sophia R. Newcomer, "Barriers to healthcare access among U.S. adults with mental health challenges: A population-based study," SSM Popul Health, June 15, 2021. doi: 10.1016/j.ssmph.2021.100847. PMID: 34179332; PMCID: PMC8214217.

9 NYS'S APPROACH TO PERSON-CENTERED BEHAVIORAL HEALTH CARE

The Legislature seeks to understand the "current approach for addressing Person Centered care for people with behavioral health needs enrolled with Medicaid managed care plans, including but not limited to special needs managed care organizations authorized to offer HARPs and the integration of those benefits with Mainstream MMC." The following section will focus more broadly across MMC by defining person-centered care, discussing NYS's current approach, and evaluating its effectiveness.

Background

The National Institutes of Health (NIH) defines whole-person care as "looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease. It means helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of treating a specific disease, whole-person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan."

Whole-person care (or person-centered care) is built on three interdependent pillars: care model, payment model, and governance model. These three pillars must be organized around the totality of an individual's needs, spanning physical health, behavioral health, and social needs.

Care model: Person-centered care models deliver integrated physical and behavioral health care tailored to the individual's personal needs. This means that the care provided to the individual is tailored to their diagnosis or risk profile. Moreover, the care the person receives addresses their unique personal needs, including wraparound offerings such as care management and services to address social determinant of health (SDOH).

Best-in-class person-centered care models leverage mechanisms such as integrated care teams, co-location of physical and behavioral health providers, data sharing, direct investments in SDOH such as supportive and affordable housing, and collaborative care planning processes to effectively coordinate care while putting the individual at the center. For example, of 47 states surveyed by Kaiser Family Foundation, nearly half reported initiatives to promote physical and behavioral health co-location in FY 2022.[45]

Payment model: A person-centered care model cannot function without the right payment model. A fee-for-service payment model is not sufficient. Instead, the payment model must reward higher quality and value of care while giving providers flexibility to tailor treatment to patient needs. To achieve person-centered payment models in a managed care context, the state can incentivize MCOs to shift a greater share of spend into value-based payment arrangements. For example, California's CalAIM's behavioral health model proposes to "align the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care."[46]

[45] Madeline Guth, "State Policies Expanding Access to Behavioral Health Care in Medicaid," Kaiser Family Foundation, December 9, 2021, https://www.kff.org/medicaid/issue-brief/state-policies-expanding-access-to-behavioral-health-care-in-medicaid/.

[46] "California Advancing and Innovating Medi-Cal (CalAIM) High Level Summary," State of California Health and Human Services Agency, Department of Health Care Services, https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM-High-Level-Summary.pdf.

Governance model: A strong governance model is a necessary foundation to design and operate person-centered care models and payment models. Within a managed care program, the governance model is influenced by state decisions in areas including, program design, political and strategic initiatives, and oversight processes.

Whole-person care is an area of continued exploration and experimentation across state Medicaid programs, with all striving to shift the current delivery system to one that can meet the ideal state. When executed effectively, this approach has been shown to improve member satisfaction and clinical outcomes, lessen provider burnout, and reduce costs by 20%–25%.[47]

Overview of NYS's Current Approach

This report assesses NYS's approach to person-centered care for Mainstream and HARP members with BH needs using the three pillars. Assessment of the care model and payment model are combined, given their tight interplay.

Care model and payment model: NYS has three key vehicles for delivering person-centered care for members with BH needs: the patient-centered medical home (PCMH) primary care model, the Health Home model, and the Certified Community Behavioral Health Clinic (CCBHC) model. These are national concepts that many states have adopted. As of 2019, 30 states reported having PCMHs in place.[48] Nineteen states operate some form of Medicaid Health Homes as of 2022.[49] NYS was one of eight states to implement the CCBHC model in a 2017 demonstration program, and now there are more than 500 CCBHCs operating in 46 states.[50]

PCMH is a model of primary care that provides accessible, coordinated, and comprehensive care with a commitment to quality improvement. It is a model used nationally to make primary care more patient-centered and to move toward greater BH integration. While not all PCMH practices have fully integrated BH, they all must adhere to core principles on care coordination, care management, care transitions, and quality reporting that are critical to BH. NYS is often considered a leader in PCMH, with 20% of all PCMH-recognized practices nationally located in NYS.[51] Moreover, the influential Center for Health Care Strategies highlights NYS's model as one of three state exemplars that go beyond typical standards for PCMH.

In the PCMH model, the PCP acts as the "quarterback" to connect members to other wraparound services. The PCMH model integrates primary care with public health, social services, and behavioral health. For example, NYS requires PCMHs to screen for SUD. From a payment model perspective, PCMH requires upside risk contracts and can have additional performance incentives through the Medicaid PCMH Incentive Program. PCMH spending also counts toward MCOs' requirement to achieve a certain threshold of value-based care spending.

[47] Wayne B. Jonas and Elena Rosenbaum, "The Case for Whole-Person Integrative Care," National Library of Medicine, June 30, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8307064/.
[48] "States That Reported Patient Centered Medical Homes in Place," Kaiser Family Foundation, https://www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place.
[49] "Medicaid Health Homes: An Overview," Centers for Medicaid & Medicaid Services (CMS), March 2022, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.
[50] "Certified Community Behavioral Health Clinics (CCBHC)," Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/certified-community-behavioral-health-clinic.
[51] New York State Patient Centered Medical Homes Quarterly Report, New York State Department of Health, September 2021, https://www.health.ny.gov/technology/nys_pcmh/docs/pcmh_quarterly_report_sep_2021.pdf.

The Health Home model is designed for high-risk members, such as ones with multiple chronic conditions and/or BH needs. HARP members automatically qualify for Health Homes, while Mainstream members qualify if they have either an SMI or two chronic conditions. Approximately 40,000 HARP members (22%) are enrolled in Health Homes, along with 130,000 Mainstream members (2%).[52]

Health Homes are a partnership of care-management agencies and community organizations that promote access to and coordination of care. Health Homes assign each member a care manager who is responsible for developing a care plan and helping members stick to it by providing additional support and services. Care managers, Health Homes, MCOs, and providers must work together to conduct person-centered service planning (PCSP) according to NYS DOH guidelines.

Health Homes also connect members to wraparound services. Care managers update members' personalized care plans in the Health Home data system, conduct assessments for HCBS, such as housing and job support, and assist members in navigating the care continuum (e.g., making care appointments, transportation, etc.). MCOs and Health Homes must conduct person-centered service planning according to NYS DOH guidelines for members needing long-term services and supports (LTSS) and HCBS.[53]

Health Homes are paid PMPM (value-based capitation) from the MCO for members actively enrolled. A portion of the PMPM is paid to care-management agencies for services delivered by care managers.

CCBHCs deliver a blend of mental health, substance use disorder, and physical health treatment services. They are required to provide crisis mental health services, screening and assessments, patient-centered treatment planning, targeted case management, psychiatric rehabilitation services, and peer support and counseling services, among other services. The goals of the CCBHC model include improving access to treatment, reducing preventable admissions, building better relationships between hospitals and community health care providers, and increasing payments to community providers working in underserved areas.

NYS has carved out CCBHCs from MMC, so they bill FFS to the state and NYS pays a single daily Prospective Payment System rate for services provided. Although CCBHC services are carved out, MCOs can still access client level CCBHC quality reporting data.

Governance model: NYS's program design choice to integrate physical and behavioral health within Mainstream and HARP coverage is an example of person-centered care. Integrated coverage is considered best practice because physical and behavioral health issues are often interrelated. For instance, 92% of health care costs for those with a BH condition come from spending on physical health needs.[54] Integrating coverage can enable tighter care coordination and aligned incentives across the

[52] New York State Office of Mental Health, internal documentation provided February 2023.
[53] Home and Community-Based Services: Person-Centered Service Planning Guides, New York State Department of Health, https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/pcp_guidance.htm.
[54] "Behavioral Health Spending Correlates with Higher Overall Healthcare Spending," LBL Group, September 8, 2020, https://www.lblgroup.com/behavioral-health-spending-correlates-with-higher-overall-healthcare-spending/.

care continuum; it has been found to improve outcomes, access, and costs while also delivering a more patient-centered experience, such as by reducing the stigma of seeking behavioral health care.[55,56]

Challenges with NYS's Approach

NYS is deploying many best practices of a whole-person care model. However, the current approach suffers from three main challenges: lack of more advanced provider and payer integration, low utilization of integrated programs, and the absence of a unified state approach.

Lack of more advanced provider integration: There are gaps in provider integration, despite NYS's integrated coverage of physical and behavioral health benefits.

Provider integration refers to the extent physical and behavioral health care happen simultaneously and in a coordinated manner, such as providing behavioral health screenings at physical health visits. NYS's model has set up appropriate structures and programs to encourage further integration, but interviews suggest they are not being fully used. For example, physical and behavioral health care teams are meant to be integrated, but only 50% of care-management records reviewed for HARP members list any physical health conditions.

NYS also has models outside of managed care (i.e., only paid for FFS), such as the Collaborative Care Model (CoCM), that emphasize greater integration of physical and behavioral health. The CoCM has grown 10x in provider participation from 2015 to 2022.[57]

Low utilization of integrated programs: Many members eligible to use person-centered services are not using them. 68% of members are affiliated with a PCMH-recognized PCP, but case record reviews show that 53% of high-need BH members had not seen their assigned PCPs in the prior 12 months.[58] This low rate inhibits the state's ability to provide person-centered care. As discussed in Section 8, Health Homes have low utilization. Just 21% of HARP members are enrolled even though they are automatically qualified.

There are several possible reasons for this low utilization, including workforce challenges and gaps in care coordination. Turnover at some care-management agencies in NYS can be as high as 50% annually.[59] Agencies with high turnover rates have to invest significant time and resources to onboard and train new staff. Moreover, OMH interviews acknowledged ineffective interaction between providers, MCOs, Health Homes, and care-management agencies that can lead to a clunky member experience and ultimately low utilization.

Absence of a unified state approach: PCMH, Health Homes, and CCBHCs are treated as separate initiatives. They are promoted and used in different ways for those with BH needs, instead of being part of a holistic state approach to whole-person care. NYS can consider where the PCMH, Health Home, and CCBHC programs optimally fit together to deliver person-centered care, taking a population-segment

[55] "Integrating Primary Care and Behavioral Health to Address the Behavioral Health Crisis," The Commonwealth Fund, September 15, 2022, https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis.
[56] "Integration of Medicare and Medicaid Services Is Essential for Dually Eligible Individuals with Behavioral Health Needs," Health Affairs, July 14, 2022, https://www.healthaffairs.org/content/forefront/integration-medicare-and-medicaid-services-essential-dually-eligible-individuals.
[57] New York State Office of Mental Health, internal documentation provided February 2023.
[58] Ibid.
[59] Michael Fagan, "Opinion: Lessons Must Be Learned from NYS Experiment in Mental Healthcare Funding," City Limits, September 18, 2020, https://citylimits.org/2020/09/18/opinion-lessons-must-be-learned-from-nys-experiment-in-mental-healthcare-funding/.

approach. The state can also consider ways to incentivize stakeholders to utilize person-centered care strategies more holistically. NYS can look to learn from other states that have taken comprehensive approaches to whole-person care, such as California and Massachusetts**.**

From 2016 to 2021, California conducted 25 regionally focused pilots for whole-person care that provided comprehensive services for 250,000 high-need members through a localized, community approach. County health departments or public hospitals were responsible for driving collaboration with community organizations and MCOs.[60] Initial results from the state showed $400 per member per month cost reduction, with 130 fewer ED visits and 45 fewer hospitalizations per 1,000 beneficiaries.[61] OHIP has proposed a similar regional coordination approach in the pending NYS 1115 Demonstration Waiver amendment proposal. As more results are released from California's model, NYS can apply learnings to its own approach.

Massachusetts has a unique program design where provider-led Accountable Care Organizations (ACOs) act as MCOs. This is an advanced provider model approach to managed care that is inherently value-based, putting ACOs at the helm of care delivery and coordination. The model also offers three distinct levels of care coordination depending on members' needs. As a baseline, all members receive care coordination from their PCP, while higher-risk members receive additional support from ACOs and community partners. The ACOs are financially accountable for the cost and quality of care, and they must use VBP initiatives with participating PCPs. All ACO payments are risk-adjusted not only for health and disability status, but also for SDOH needs, such as homelessness.

Conclusions

While NYS has integrated physical and behavioral health coverage, in practice, provider and payer integration and utilization of integrated programs are limited. Key reasons for this limited integration are gaps in care coordination and improper claims denials. Furthermore, NYS has pursued disparate whole-person care initiatives, resulting in redundancies. NYS can look toward defining a holistic person-centered care approach and using procurement, contract standards, and contract enforcement to select and manage MCOs in support of that vision.

[60] Emmeline Chuang, Nadereh Pourat, Leigh Ann Haley, Brenna O'Masta, Elaine Albertson, and Connie Lu, "Integrating Health and Human Services in California's Whole Person Care Medicaid 1115 Waiver Demonstration," Health Affairs, April 2020, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01617.

[61] Eric Wicklund, "California's 'Whole Person Care' Program Reduced Medicaid Costs for High-Risk Patients," Healthleaders Media, February 9, 2023, https://www.healthleadersmedia.com/innovation/californias-whole-person-care-program-reduced-medicaid-costs-high-risk-patients.

10 EVALUATION OF CERTIFICATION AND PROCUREMENT

In Sections 6–9, this report detailed the challenges confronting the MMC market today. Now, this report shifts to discuss three state levers that can be used to address these challenges and improve MCO performance: 1) selecting plans through either certification or procurement; 2) optimizing the model contract; and 3) enforcing the model contract through ongoing oversight of MCO performance. Section 10 and 11 cover the first lever, selecting plans; Section 12 covers the other two levers, optimizing and enforcing the contract.

Background

With its "any willing plan" certification model, NYS is one of six states with MMC that does not utilize procurement to select its MCOs. NYS uses procurement as the mechanism to award contracts for most privatized services. The other five states that do not utilize procurement are Arkansas, Colorado, Maryland, New Jersey, and South Carolina.[62] The remaining 35 of the 41 states with MMC[63] use procurement.

To raise standards for participation in the market, NYS can choose either to raise certification standards or shift to a procurement model. If NYS proceeds with certification, the state will need to change certification standards through statutory changes and then decertify any plans that do not meet the new standards. If NYS opts to conduct a procurement, NYS will need to craft an RFP aligned to state goals and then select from the respondents. It would also need to re-bid periodically at the end of the contract term.

This section explores the tradeoffs of each approach based on benchmarking and case studies of other states' recent procurements. This report benchmarks other states' most recent MMC procurements since 2015, comprising 31 completed Mainstream and/or MLTSS procurements across 26 states, plus three canceled procurements and five in-progress procurements. Five procurements were selected for more detailed case studies: California Mainstream, Ohio Mainstream, Pennsylvania Mainstream, Pennsylvania MLTSS, and Indiana MLTSS. These case studies were selected for their recency, size of the state, and a Medicaid population comparable to NYS.

Key Findings

The table below shows potential new certification standards NYS could enact and enforce on plans to raise MCO performance and address current market challenges. MLTC Partial is used as an illustrative example. The table also includes potential performance thresholds that could trigger penalties for the plan, including decertification or loss in a procurement. These standards and cutoffs are illustrative only and are not recommendations for the exact text of state standards.

Exhibit 10.1:	Hypothetical Standards to Address Top Challenges in MLTC Partial
Data source:	N/A (Summary of Section 6)

[62] Based on publicly available data and benchmarking of MMC procurements since 2015.

[63] Elizabeth Hinton and Jada Raphael, "10 Things to Know About Medicaid Managed Care," Kaiser Family Foundation, March 2023, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

Top challenges in MLTC	New standard(s) to enact and enforce	Potential threshold
Lower average performance among small plans, including on administrative cost, profitability, Medicare alignment, and quality	• Require a minimum plan enrollment (e.g., 10,000) • Require fiscal solvency at a maximum allowable administrative reimbursement or minimum MLR (e.g., premium income P&L PMPM > excess admin cost PMPM)	• 10,000 enrollment • Plans ALR must be greater than state average ALR over 3-year time period
Large number of plans in market increases provider and state contracting & oversight burden	• Select a targeted number of plans • Require a minimum plan enrollment	• 4 plans per region (in line with peers) • 10,000 enrollment
Lack of high-quality Upstate plans	• Require a minimum NYS Consumer Guide plan rating • Devise a new aggregate quality metric for evaluation • Require plans to serve specific regions	• Rating of 3+ • Require NCQA accreditation • 2022 CMS HCBS standards • Upstate service requirement by region rather than county
Limited alignment with Medicare	• Require alignment with a dually-integrated offering	• Must offer high-quality MAP plan, with 3+ star Medicare quality rankings
Limitations of current network adequacy standards to ensure provider access	• Require workforce availability for HCBS	• Minimum worker to member ratio

While NYS could raise standards through either certification or procurement, procurement is likely to be more feasible and more effective. Given that there are few states that are not already procuring MCOs, there are no recent examples of a state moving from certification to procurement to allow for direct evaluation of procurement as a lever of outcomes improvement. However, benchmarking and case studies of recent procurements show that procurement is effective in driving program goals for four key reasons. Procurement allows states to set priorities and require clear MCO responses; sets an optimal number of MCOs; drives competition, innovation, and accountability; and scores more holistically through a broader, strategically weighted set of both quantitative and qualitative measures.

Set priorities and require clear MCO responses: RFPs serve as clear statements of the state's priorities. RFPs require MCOs to respond directly to those priorities and give NYS the opportunity to see what is out there. This assessment of "state of the art" is a best practice across government procurement when the vision is clear but the solution is not. Publicly stated goals are kept broad, but technical criteria within RFPs are tailored to state priorities and commonly include questions on quality management, provider access, and care coordination.

For example, expert interviews on the 2020–2022 California procurement reveal that the state considered their managed care procurement and their signature CalAIM whole-person care policy linked; California used procurement to ensure they had the right market players and contract requirements to implement the enhanced BH and social-need services that are the cornerstones of CalAIM.[64]

As another example, Virginia's Secretary of Health and Human Resources framed the state's $14 billion procurement planned for 2024 as transformational to advance program goals including driving innovation and strengthening quality and accountability in its managed care program.[65]

Procurement can also serve as an opportunity to engage stakeholders in defining strategic priorities. For example, Michigan recently engaged over 10,000 residents to help develop five strategic pillars for its

[64] CalAIM: Our Journey to a Healthier California for All, https://www.dhcs.ca.gov/calaim.

[65] „Virginia Medicaid to Transform Managed Care," Commonwealth of Virginia, Virginia Department of Medical Assistance Services, October 4, 2022, https://www.dmas.virginia.gov/media/5116/10042022-press-release-virginia-medicaid-to-transform-managed-care-2.pdf.

upcoming re-procurement; 85% of the respondents were from Medicaid members or their families, and the remaining 15% were other health care stakeholders, including plans and providers.[66]

Set an optimal number of MCOs: States may publicly communicate a target range or number of MCOs to be awarded contracts, either statewide or per region. Of five procurements explored in detailed case studies, three (Indiana MLTSS, Ohio Mainstream, Pennsylvania MLTSS) communicated an explicit target number of MCOs in their procurements, ranging from two to five MCOs per region or statewide. Each state largely stuck to these targets, each awarding three to seven total MCO contracts. Looking more broadly at the 31 procurements profiled since 2015, a range of one to 11 MCOs were awarded contracts per state or region. The majority (~75%) of states awarded between three and six contracts. No state awarded bids to as many MCOs as NYS currently has in the Mainstream market (12). Certification, on the other hand, does not allow DOH to directly set a fixed number of plans with which to contract. Achieving higher plan sizes could help drive improvements in cost, quality, member and provider experience, and state oversight.

Drive competition, innovation, and accountability: Procurement encourages bidders to strive to be the best, while certification merely sets a minimum performance floor. 85% of procurements profiled were competitive, meaning not all bidders were awarded. States selected two-thirds of bidders on average. Furthermore, re-procurement allows the state to routinely test the market for new ideas, reset contract standards, and provide a clear check on low performance if plans want to remain in the market through periodic re-bidding. The majority (over 70%) of the procurements profiled since 2015 were re-procurements.

Certification does not regularly prompt competition, nor does it push the market toward innovative solutions as explicitly, thereby limiting the state's ability to drive best-in-class performance and hold underperforming plans accountable. DOH has no recent record of decertifying any plan (which would be analogous to a re-bid), despite having broad statutory authority[67] to do so. If NYS decides to pursue market improvement by raising certification standards without a procurement, it should consider increasing legislative clarity around the state's authority and process to decertify plans to ensure that it can credibly and legally hold plans accountable to higher standards.

Score qualitatively and quantitatively: Procurement allows DOH, through a scoring rubric, to evaluate plans more holistically. Certification requires evaluation to be all or nothing, creating many must-haves with no relative prioritization among them. An RFP enables evaluation on a broader range of qualitative factors, including both past and future potential performance. By contrast, certification requires more quantitative measures.

RFP scoring also allows states to reward bidders on priorities that may be less quantifiable, such as approach to whole-person care, tackling disparities, or striving for health equity. States that have begun prioritizing social determinants of health (SDOH) and/or community reinvestment strategies in their Medicaid programs are able to specifically tie such goals to requirements in an RFP. For example, D.C. and Minnesota weighted SDOH-related questions with over 25% of total available points in the procurement.[68] California solicited information in its RFP to assess MCOs' track records in addressing

[66] "MIHealthyLife Will Strengthen Health Care Coverage for Michiganders," Michigan Health & Human Services, April 7, 2023, https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2023/04/07/mihealthylife.
[67] 10 NCRR 98-1.8 (a).
[68] "States Are Cultivating a Medicaid Marketplace Where MCOs Must Provide Their Worth," Guidehouse, September 22, 2022, https://guidehouse.com/insights/healthcare/2022/blogs/medicaid-marketplace-mcos-prove-worth.

SDOH, such as asking MCOs to provide specific examples of social needs that were discovered through population-level assessments and how those findings informed specific person-centered, targeted interventions that were a part of the proposer's population health management, quality improvement, and Health Equity programs.

While it offers many benefits, procurement—or decertification—is not without risks, particularly MCO pushback and a negative impact on members. However, states have proven tactics to help manage these issues. First, appeals and litigation from losing bidders occur in nearly every procurement profiled. The size of MCO contracts today creates a strong inventive for any procurement losers to file appeals, even if unfounded, and try their hand in court. However, the procurement case studies detailed below demonstrate that having sufficient internal resources to manage the procurement effort, engaging with stakeholders before the bid, having a clear, transparent procurement process that follows state law, and documenting that the state is following established processes helps win appeals. For example, Ohio and Indiana engaged in extensive stakeholder engagement prior to RFP release. Pennsylvania awards were upheld after four appeals.

Second, given that most bids are competitive, it is common for members to need to change plans if their current MCO is not selected for a new contract. Between 20% and 30% of members in benchmarked states needed to change plans following a procurement, based on available data. Members who need to switch plans may benefit if the state selects top-performing plans in a procurement, as they are likely to be moved to higher-performing plans. Such transitions would likely occur in decertification as well. States can support smooth transitions by enforcing contract requirements to ensure members have continuity of care while terminated plans are phased out. States also ensure that their operations and technology systems are robust enough to support member transitions. Despite these risks, states are generally successfully in completing their procurements. Canceled procurements are quite rare, with only three known cancellations out of 34 since 2015.

In the MLTC market, a procurement has additional benefits including selecting the optimal overall number of plans to address fragmentation, improving quality, lowering administrative costs, and driving greater integration for dual-eligibles.[69]

Procurement could also allow DOH to make wholesale changes to the provision of BH services, impacting the Mainstream and HARP market. Procurement allows for a broader discussion of BH goals and how the managed care program can achieve those goals in product design; the flexibility of procurement is necessary to fully consider available product options. Further, in a procurement, the state could score bidders based on past performance and past deficiencies or findings, and/or ask specific RFP questions to understand the plan's approach to integration. Regular re-bidding in a procurement would serve as another enforcement mechanism of compliance with BH standards, such as quality, access, and parity. More broadly, a Mainstream procurement would allow the state to specifically test the market and innovate on its policy goals, including on integration of social determinants into managed care as part of the 1115 waiver proposal, or a more specific focus on health equity and quality measures that targets disparity.

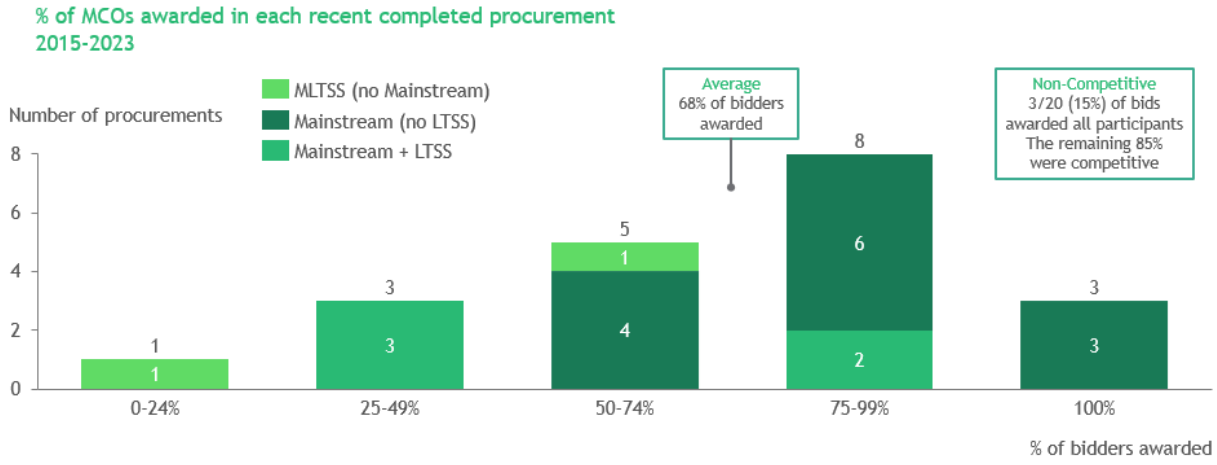
Additional Detail from Procurement Benchmarking

[69] "New York State's Master Plan for Aging," New York State, https://www.ny.gov/programs/new-york-states-master-plan-aging.

Evidence from recent Mainstream and MLTSS procurements across the country points to differences in how states approach procurement. Of the 31 completed procurements profiled across 26 states since 2015, differences occur in the following areas:

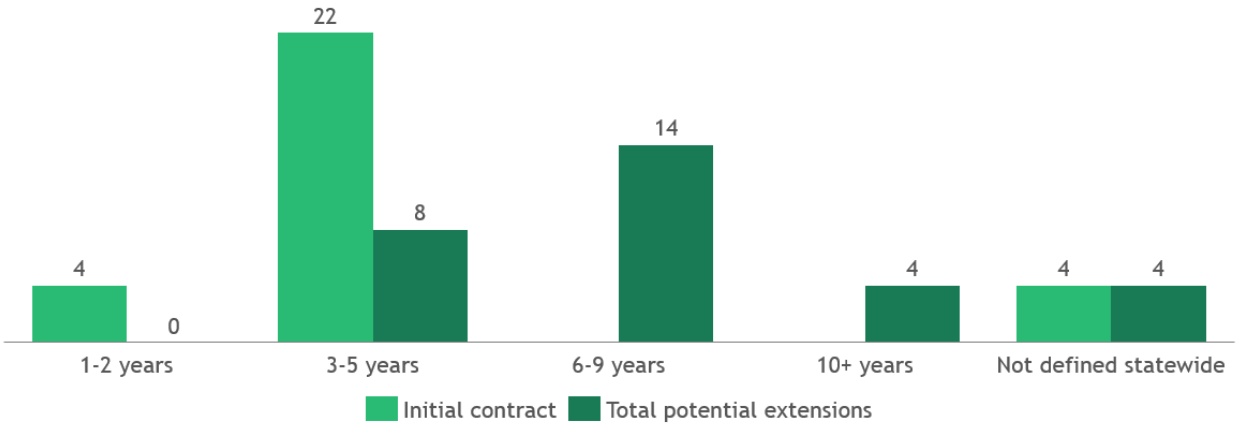
- Lines of business procured: 19 (61%) focused on Mainstream, six (19%) on MLTSS, and six (19%) procured both Mainstream and MLTSS at the same time. Not all states included in the benchmark set have MLTSS, contributing to the lower proportion of MLTSS procurements.
- Geography procured: 10 procurements were for specific regions within a state, 17 were statewide only, and four had components that were both regional and statewide (e.g., some MCOs were given a statewide contract, and others were carved out in certain regions only).
- Goals of procurement: Based on a scan of public press releases and commentary, the most common broad goals articulated by states include improving outcomes (12) and access (nine), increasing cost efficiency (eight), integrating care (five), and/or providing whole-person care (two).
- Number of MCOs awarded: 85% of procurements were competitive, with states on average awarding contracts to two-thirds of bidders. A range of one to 11 MCOs were awarded contracts. The majority (~75%) of states awarded between three and six contracts. A histogram detailing the number of awardees is shown below.

Exhibit 10.2:	Percentage of MCOs Awarded in Each Completed Procurement, by Line of Business
Data source:	Publicly Available Data, For Procurements 2015-2023



- Procurement timeline: Total time from RFP to implementation ranges from seven to 35 months, with an average of 14 months. This timeline can be further broken down into two segments:
    - RFP release to contract award: Ranges from three to 14 months, with an average of seven months.
    - Contract awards to implementation: Ranges from one to 26 months, with an average of seven months.
- Re-procurement frequency: 22 of the 31 completed procurements were re-procurements, with states re-procuring after five to eight years since the last procurement.
- Contract duration: Initial contract durations ranged one to five years (with most three to five years); however, maximum contract length varies given optional extensions (with most six to nine years total if all extensions were implemented).

Exhibit 10.3:	Initial and Maximum Contract Length, by Number of Recent State Procurements
Data source:	Publicly Available Data, For Procurements 2015–2023



While cancelling a procurement is relatively rare (three identified since 2015), it can happen. Research shows the three canceled since 2015 have occurred for idiosyncratic political, operational, and legal reasons.

- New Mexico canceled due to a changeover in government leadership.
- Rhode Island canceled due to submission issues from bidders and to incorporate CMS changes that constituted a material change to the RFP post-release.
- California canceled to mitigate litigation and instead directly awarded contracts to three MCO winners of the RFP plus an additional two MCOs that had challenged the initial results through appeals, PR campaigns, and lawsuits. Despite cancelling its procurement, California officials cite difficulty in driving MCO performance, the need to have strong partners to implement CalAIM, and poor contract adherence prior as reasons to have procured regardless of the outcome.

Additional Detail from Procurement Case Studies

As previously noted, five procurements were selected for more detailed case studies for their recency and relevance to NYS: Indiana MLTC, California Mainstream, Ohio Mainstream, Pennsylvania Mainstream, and Pennsylvania MLTC.

Key statistics across these five procurements are summarized in the table below, followed by the case studies. A complete set of data sources for the case studies is in the appendix.

Exhibit 10.4:	Summary of Procurement Case Studies
Data source:	Publicly Available Data for Selected Recent Procurements 2015–2023

	IN MLTSS	CA Mainstream & LTSS	OH Mainstream	PA Mainstream	PA MLTSS
RFP release	June 2022	February 2022	September 2020	October 2019	March 2016
RFP award	March 2023	August 2022/ December 2022	April 2021	July 2020	August 2016
Key goals	Person-centered LTSS, smooth member transitions, access	Integration/coordination of PH/BH/LTC, access, equity, person-centered care data transparency, community re-investment	Personalized care, care coordination, population health	Quadruple aim, value-based care, access, person-centered care	Care coordination, quality, service integration, person-centered care
Geographic structure	Statewide	County	Regional	Regional	Statewide & regional
Additional context	MLTSS program implementation	First competitive procurement	Re-procurement, conducted 2 RFIs	First time procuring regions together	MLTSS program implementation
Number members	100K	~4M	2.8M	2.7M	~150K
Target # MCOs	3	Varied by county	<5 per region	Varied by region	2-5 per region
Number of bidders	7	8	11	8	14
Number awarded	4	3/5	7	6	3
Contract length	4 years	5 years	2 years	5 years	5 years
Members needing plan change	n/a	~1.2M (30%)	Not available	~500k (20%)	n/a
Number of appeals	Appeals window still open	4	1	4	5
Appeal/litigation results	n/a	Procurement canceled; direct contracts awarded to subset of bidders	Denied and denial upheld in court	Denied and denial upheld in court	All denied
Implementation date	January 2024	January 2024	February 2023	September 2022	2018-2020 phased roll out

Case Study #1: Indiana (MLTSS, Statewide)

Indiana released an RFP in June 2022 for the implementation of a statewide MLTSS program; contracts for plans covering ~100,000 members were awarded in March 2023. While the state originally set a target of three MCOs to operate statewide, it ultimately awarded contracts to four. As the program and RFP were being designed, Indiana solicited feedback from MCOs by conducting workgroups and stakeholder engagement sessions. Goals of the procurement and implementation of MLTSS broadly include providing person-centered services and supports, ensuring smooth member transitions and increasing access to services. Applications were scored on covered benefits and services, provider network, quality, utilization management, and commitment to work with local and minority subcontractors.

Four of seven bidders were selected for four-year contracts. All three of the losing bidders were incumbent Mainstream MCOs in Indiana. As of the writing of this report, appeals window was still open, and no appeals had been filed. Implementation is targeted for January 2024.

Case Study #2: California (Mainstream, Including Carve-In of LTSS, Regional/County)

In its first-ever Medicaid procurement process, California released an RFP focusing on private plans in February 2022 for 21 counties representing about four million MMC members, with contracts awarded in August 2022. This procurement followed other contracting changes to the public plan and statewide plan model.

California has six different managed care models depending on the region or county. This procurement process covered three of the six models. Each county chose which model to use for the procurement. The target number of MCOs depended on the county and its model.

Goals of the procurement included integration and coordination of physical health, behavioral health, dental care, and long-term care; timely access to care; health equity; population health; person-centered and culturally competent care; community reinvestment and engagement with community advisory groups; and increased data transparency. California required bidders to also offer a D-SNP in

the counties in which they bid for contracts. Applications were scored on 25 sections including quality improvement, network and access to care, population health and coordination of care, care management, community support, and mental health benefits.

Three of eight applicant MCOs were originally chosen in August 2022 for five-year contracts. This would have caused ~2.4 million members (~60%) to choose or be assigned to a new plan. Four MCOs (three that were not granted contracts and one that was granted a contract but only in a subset of counties it applied to serve) filed appeals. In addition to appealing, three of the MCOs sued on the grounds that the agency issuing the RFP had not released documentation on the scoring process and methodology. In December 2022, the state rescinded the August awards, canceled the RFP, and directly awarded contracts to the three original winners as well as to two additional MCOs (of the three that sued). With the announced expansion to five MCOs, ~1.2 million (30%) of members will need to select a new plan. The new state award decisions have a targeted implementation date of January 2024.

California is the only state profiled that changed its decision on contract awards based on bidder protests and litigation. Because the state's market is intricate and given some of the MCOs were established players with decades of historical market experience, the change to market composition with a competitive selection process was likely to be contentious regardless of procurement design and execution. However, California officials—citing difficulty in driving performance and contract adherence prior to adoption of a procurement process—continue to state that procurement was necessary for contract redesign to implement CalAIM and adequate state oversight.

Case Study #3: Ohio (Mainstream, Regional)

Ohio released an RFP in September 2020 for a Mainstream re-procurement process covering 2.8 million members and awarded contracts in April 2021. Prior to this procurement, Ohio issued two requests for information (RFI) that allowed stakeholders, including members, providers, community organizations, and others, to provide input that was incorporated into the MMC RFP and program design. The state procured bids in its three existing regions, stating there would now be no more than five MCOs per region. The procurement was a core initiative in the state's rollout of its next-generation model for its Medicaid program; goals of the procurement included expanding personalized care and increasing coordination. Applications were scored on qualifications and experience, population health, benefits and service delivery, and operational excellence and accountability.

Seven of 11 MCO bidders were selected for two-year contracts. Two incumbents were not awarded contracts. There was only one protest from a losing bidder, on the grounds that the state had abused its discretion in scoring—a claim that was denied by the state, with the denial subsequently upheld in court. The state might have mitigated the risk of legal challenges by explicitly seeking input from a variety of stakeholders in the period leading up to the procurement. Contract implementation was delayed until February 2023 due to the need for Medicaid eligibility redetermination at the end of the public health emergency.

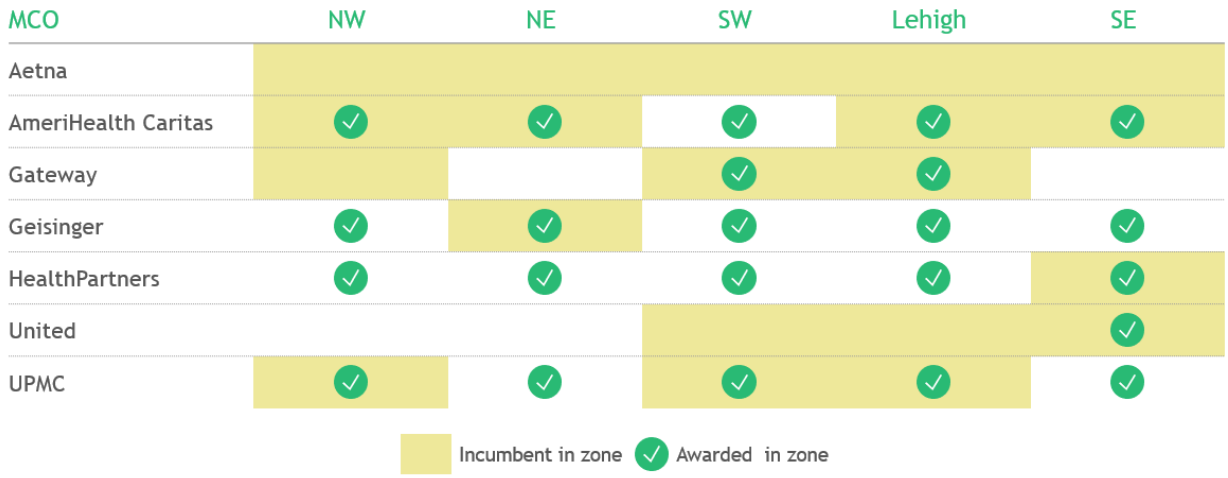
Case Study #4: Pennsylvania (Mainstream, Regional)

Pennsylvania released an RFP in October 2019 for physical health MCO contracts covering 2.7 million members, contracts that were awarded in July 2020. All five of the state's regions participated in the same procurement process for the first time; previously, each region had conducted its own procurement. Each region had a target number of MCOs based on population, DOH experience, and

regional oversight capacity. Goals of the procurement included achieving the quadruple aim, increasing value-based care, increasing access, and expanding person-centered care. Applications were scored on soundness of approach, including through sections on care management, care coordination, VBP, and quality management.

Six MCOs – all incumbents – out of eight bidders were awarded five-year contracts. One of the losing bidders (Aetna) was an incumbent and the other was not (Centene). The table below details the seven incumbents' presence in the Pennsylvania market before and after the procurement. The results demonstrate that even when only incumbents are awarded, a procurement can still shift the market landscape. Prior to the procurement, Aetna was the only plan with a statewide presence, and it was eliminated. Meanwhile, four of the winning incumbent MCOs were awarded contracts in all regions, expanding their coverage and shifting the market to more of a statewide approach. The other two incumbent MCOs were awarded contracts in a subset of regions, both losing regions through the procurement process.

Exhibit 10.4:	Pennsylvania Mainstream Incumbent Plans' Market Presence, Pre- & Post-Procurement
Data source:	Pennsylvania Health Law Project[70]



Furthermore, the results highlight that procurement can be an effective mechanism to eliminate poor-performing incumbent plans. The table below shows the incumbent plans' performance on 11 of the 13 key HEDIS measures used to analyze Mainstream quality performance in this report and used by NYS in their QARR; data was unavailable for the other two metrics. Green indicates high performance and red indicates the low performance relative to the average. As is clearly shown in the heatmap, Aetna was the poorest performer on these measures, as the only MCO with more than half of the measures in the red.

Exhibit 10.5:	Pennsylvania Mainstream Incumbent Plans' Performance on Select HEDIS Measures
Data source:	Pennsylvania 2018 EQRO Report

[70] Fisher, Kyle, "DHS Targets July Launch for HealthChoices Changes," Pennsylvania Health Law Project, January 25, 2022, https://www.phlp.org/en/news/dhs-targets-july-launch-for-healthchoices-changes.

HEDIS measure	Mean	Aetna	Ameri-Health	Geisinger	Gateway	Health Partners	United	UPMC
Plan All-Cause Readmissions (18-64)	12.1	10.2	10.7	12.1	16.1	9.6	13.2	10.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	72.5	65.5	76.8	73.4	63.1	75.4	77.4	70.4
Well-Child Visits in the First 15 Months of Life (>5 visits)	70.8	65.7	72.5	74.9	68.4	68.4	74.5	68.1
Timeliness of Prenatal Care	86.2	82.0	90.0	86.6	81.5	89.3	84.4	91.2
Asthma Medication Ratio	64.7	64.1	68.7	64.5	68.2	65.4	60.1	66.7
Breast Cancer Screening	57.2	45.7	63.1	58.9	54.5	63.3	50.9	57.5
Comprehensive Diabetes Care– HbA1c Control (<8%)	52.2	48.0	51.6	55.5	45.6	55.3	52.5	55.1
Controlling High Blood Pressure	64.6	60.8	65.9	70.5	52.3	69.7	65.7	65.9
Statin Therapy for Patients With Diabetes– Statin Adherence 80%	66.6	59.1	77.3	62.5	61.6	65.0	59.6	65.5
Follow-Up Care for Children Prescribed ADHD Medication	41.1	28.4	25.1	38.4	54.1	58.0	59.7	52.0
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence– 7-day rate	14.7	15.5	14.1	15.0	14.4	12.0	15.4	18.1

Approximately 500,000 members in Pennsylvania (~20%) had to choose or be assigned to a new plan as a result of the procurement. While there were four protests (two from MCOs that did not win any contracts and two from MCOs that were awarded contracts in only a subset of the regions where they bid), all denials of appeal by the state were ultimately upheld in court. Contracts were implemented in September 2022. Although two prior attempts at using a procurement process for Mainstream had been ultimately negated due to protests and litigation, Pennsylvania, by conducting the procurement precisely according to due process, was able to prevail in award decisions in 2020.

Case Study #5: Pennsylvania (MLTSS, Statewide)

Prior to and separate from the procurement process described in Case Study #4, Pennsylvania released an RFP to implement MLTSS in March 2016 for 150,000 members, with contracts awarded in August 2016. The state used the same regions as in its Mainstream program (with a target of two to five MCOs per region) and planned to phase in the MLTSS program, by region, over three years. Goals of the procurement included strengthening coordination of care, increasing quality, and expanding person-centered care. Applications were scored on participant service coordination and care management, service integration, and quality improvement.

Three MCOs out of 14 bidders were awarded five-year contracts to operate statewide in the MLTSS program. Two of the three winners of the MLTSS contract are now, as a result of the 2020 Mainstream procurement detailed above, also Mainstream awardees that operate statewide. Five of 11 losing bidders filed protests, but ultimately they all were withdrawn or denied on technicalities. Implementation occurred from 2018 to 2020. Pennsylvania awarded contracts to only a few bidders from a large field of applicants yet was able to successfully manage appeals and litigation and implement its new program.

Conclusions

While NYS could address the challenges confronting the MMC market today by raising certification standards, procurement is likely to be more effective. Of the 41 states with MMC, 35 use procurement as a mechanism to communicate and advance their goals; set an optimal number of market players; regularly drive competition, innovation, and accountability; and score MCOs more holistically and with more nuance than certification allows. Procurement is a proven tool not only for other states' MMC programs, but also for NYS, as it routinely uses procurement for other government contracting.

11 PROCUREMENT SCENARIOS

Background

The legislative text asks for an assessment of the potential impact of an MMC procurement, specifically cost savings, access to providers, and disruptions in member enrollee service and provider contracts.

As discussed in Section 10, this report did not find an example of another state transitioning from certification to procurement. Furthermore, given limitations in publicly available data, this report did not find empirical evidence on the direct impact to outcomes, cost, and other goals that different states have achieved through procurement.

Therefore, to assess the potential impact of an NYS procurement, this report models illustrative scenarios based on the historical performance of NYS plans and a set of hypothetical plan selection standards aligned to state goals. The scenarios assume that plans that fail the standards based on historical performance are removed from the market, and then the characteristics of the resulting market are modeled. Comparing this hypothetical post-procurement market landscape with the status quo across different scenarios gives an estimate of the potential impact of a procurement to cost, access, members, and providers.

Methodology: Definition of Scenarios

A procurement "scenario" is defined here as the combination of 1) a set of lines of business that are procured together (either MLTC Partial and MAP together, or Mainstream and HARP together); and 2) a plan selection standard aligned to a state goal.

This report defined and modeled three scenarios for MLTC and three for Mainstream/HARP. The market's top challenges informed the plan selection criteria modeled.

As discussed in Section 6 of this report, the MLTC market is facing several major challenges, including:

- Low administrative cost and profitability driven by small plans: Small plans have 14% higher average administrative costs and are less profitable.
- Upstate quality issues: Based on NYS's MLTC Consumer Guide plan ratings, members lack high-quality plan choices Upstate, where there are no five-star plans (highest rating) and a greater share of one-star plans (lowest rating).
- Limited care integration: While the vast majority of MLTC members are dual-eligible for Medicare (~90%), based on 2021 data, most dual-eligible MLTC members (~84%) would require a plan or carrier change to receive integrated care with Medicare. Note that some of these members could move to a MAP plan under the same carrier; 74% of members are in plans that offer MAP.

To address these challenges, the MLTC procurement scenarios are as follows:

1. Cost and value: Require plans be financially solvent if reimbursable administrative costs are capped at the statewide median. In other words, require plans to still be profitable if they were to absorb any administrative costs incurred above the statewide median administrative loss ratio (ALR).
2. Quality: Require plans to achieve a 3+ star standard on quality on the NYS Consumer Guide.

3. Alignment of care: Require MCOs with MLTC Partial plans to offer a MAP plan to their dual-eligible members.

As discussed in Sections 7, 8, and 9 of this report, the Mainstream/HARP market is facing several major challenges, including:

- Not all plans have best-in-class financial performance: Plans spend different percentages of their revenue on administration (as measured by their administrative loss ratio, or ALR), and many plans are historically unprofitable. Small plans are less profitable and have higher administrative costs than large plans.
- Not all plans have best-in-class quality performance: In the current market, there is a 16% difference between the highest and lowest plan on an aggregate HEDIS quality score.
- Deficiencies in access to behavioral health services in certain counties: Across 17 metrics tracked for BH service network adequacy, a range of 14% to 24% of networks are deficient across plans (based on OMH analysis and our independent analysis, respectively, with a deficiency defined as any instance of a plan failing to meet one of the BH network standards in a county).

Based on these challenges, the Mainstream/HARP procurement scenarios are as follows.

1. Cost and value: Require plans be financially solvent if reimbursable administrative costs are capped at the statewide median. In other words, require plans to still be profitable if they were to absorb any administrative costs incurred above the statewide median administrative loss ratio (ALR).
2. Quality: Require plans to have a majority of their quality incentive metrics above the state's current average.
3. Behavioral health access: Require plans to reduce their BH network deficiencies to below the state's current average (18%).

These scenarios were selected because they focus on state priorities, address current market challenges, and have quantifiable associated metrics to use as criteria. Other state goals (e.g., SDOH, equity, and provider experience) are important but less quantifiable given available metrics.

Methodology: Evaluating Scenarios

Evaluating a scenario is a three-step process.

- Review each plan in the chosen line of business (LOB) grouping (MLTC Partial/MAP, Mainstream/HARP) against the selection criteria based on historical performance data, eliminating plans that did not meet the criteria.
- Reassign members from eliminated plans to remaining plans, proportionate to remaining plans' current market share.
- Determine hypothetical new market performance based on plans remaining in the market statewide and regionally using historical data. The impact depends on the criteria applied, so scenarios illustrate a range of impact. New market performance was evaluated against the below metrics, which are tied to legislative text requirements and state goals.
    - Statewide fragmentation (number of plans, average plan choice per county, number of counties with low plan choice, average number of plans)
    - Administrative cost savings
    - Member impact
    - Provider impact
    - Quality of care

- Alignment of care

Additional detail on the impact metrics assessed can be found in the appendix.

Methodology: Limitations of the Approach

The most critical limitation is that no plan or market adaptation is modeled (plans' past performance is assumed to determine their future performance), even though the market is likely to adapt prior to a procurement milestone. Furthermore, plans' performance may change over time as the market evolves. For example, if the procurement selects certain high-performing plans, that does not necessarily guarantee the plans will maintain their strong performance throughout the contract period. Effective contract standards and active contract management are still required to drive plan performance toward state goals. Additionally, the historical performance data used in the analysis may differ from current plan performance even before factoring in potential market adaptation. One other limitation is that scenarios are defined by binary criteria, whereas in a procurement process, the state will evaluate and score plans on multiple quantitative and qualitative metrics.

Given these limitations, actual member and provider impact may be lower (or greater) than what is modeled, and improvements to cost, quality, and access may be greater (or lower).

Overall, this is a theoretical exercise; the analysis should be seen as providing the directional impact of procurement. These scenario-based projections are not intended as policy recommendations, nor a predictive model of how enforcing certain standards would necessarily play out.

Key Findings: MLTC

Across the three scenarios modeled, high-level MLTC scenario impacts include:

- A meaningful reduction in market fragmentation, which can address key challenges (e.g., reducing provider burden, enhancing oversight, and improving quality).
  - Reduction from 25 plans to 11–18 plans (~25–55% decrease) depending on the scenario. The greatest reduction in observed fragmentation would be in NYC Metro, home to 89% of members.
  - Increase in plan size across regions and scenarios (plans currently range from 2,000 to 16,000 members; that would grow to 3,000 to 28,000 members per plan, depending on the region).
- Cost savings, but only when plan finances are explicitly used as a criterion.
  - $65 million in annual administrative cost savings projected in Scenario 1 ($35 million to $90 million, based on specific criteria); other scenarios result in estimated cost increases ($17 million to $25 million) as lower-ALR plans are eliminated.
  - This analysis holds ALR constant and does not account for potential additional administrative cost savings through economies of scale as remaining plans expand membership
- Near-term impacts to members and providers, but potential longer-term improvements to member and provider experience.
  - Up to 25% of members will change plans, although members will move to higher-quality plans. The maximum member impact is seen when selecting for alignment of care (Scenario 3), which can enhance member experience (e.g., through better care coordination).

    - Up to 20% of providers will need to recontract or else will not be part of any MCO network. However, overall provider contracting and billing burden will decrease with fewer plans.
    - There is a potential to drive MAP alignment by selecting only MCOs that offer MAP while still keeping the member and provider impact in line with other scenarios.
- Challenges with upstate plan choice and provider access, which may be mitigated through market adaptation (e.g., provider re-contracting or plan M&A) or new state service requirements.
    - Elimination of low-performing plans in underserved counties Upstate will lead to counties going from approximately three plans to one. Two specific low-performing Upstate plans are eliminated in all three scenarios, leaving 24 Upstate counties with only one plan.
    - Increase from 17 to up to 22 Upstate counties with no "active" contracted LHCSAs (i.e., LHCSAs that are serving Medicaid members today based on claims data), although LHCSAs could re-contract.
- Minimal change to quality.
    - Since the largest plans would not be impacted in any of the scenarios, the average member's quality of care would improve by 0.3 stars or less, even when quality is selected for.

The data underlying the points above are visualized in the table below, which color-codes the range of impact of procurement based on whether it is a substantial benefit or risk statewide or regionally.

Exhibit 11.1:	MLTC Procurement Scenario Range of Impact
Data source:	Scenarios Analysis (see Scenarios Methodology)

Impact measured	Metric	Range of impact (statewide)	Range of impact (regional)		
			NYC metro	East/central	West
Statewide fragmentation	Total # of plans in the market	Reduce from 25 to 11-18 plans			
Fragmentation: Plan choice	Average number of plans per county		Reduce from 12 to 7.5-10.5 plans	Reduce from 3 to 1.7-2.1 plans	Reduce from 2.8 to 1.1-1.5 plans
Fragmentation: Plan choice	# of 0- or 1-plan counties	Increase from 0 to 25-28 out of 58	Maintain 0 of 4[1] counties	Increase from 0 to 12 out of 35 counties	Increase from 0 to 13-16 out of 19 counties
Fragmentation: Sub-scale plans	Avg plan scale in region		Increase from 16K to 18-26K members per plan	Increase from 2K to 3-7K members per plan	Increase from 2K to 3-6K members per plan
Admin cost	Annual savings	Save up to $65M or spend up to $25M more			
Member impact	Number of members that change plans due to their plan being eliminated	24-73K (10-25%) members impacted	15-60K (5-25%) members impacted	4-8K (25-50%) members impacted	6-8K (50-65%) members impacted
Provider impact	Number of providers that may recontract due to all their plans being eliminated	44-127 (5-20%) LHCSAs impacted	11-80 (<5-15%) LHCSAs impacted	16-32 (20-35%) LHCSAs impacted	20-25 (30-40%) LHCSAs impacted
Provider access	# of counties with no active LHCSAs	Increase from 17 to 21-22 counties	Maintain 0 of 4[1] counties	Increase from 9 to 11-12 out of 35 counties	Increase from 8 to 10 out of 19 counties
Quality	Enrollment-weighted avg of state consumer guide plan star rating	Increase of 0-.3 in avg plan star rating			
Alignment of Care	% of members enrolled in an MCO that offers a MAP plan	Potential to increase to 100% through requirement			

Benefit of a procurement | Minor risk or potential benefit/risk depending on scenario | Risk-procurement implementation should specifically address | More extreme risk-procurement implementation should specifically address

Key Findings: Mainstream/HARP

Across the three scenarios modeled, high-level Mainstream scenario impacts include:

- Substantial administrative cost savings in every scenario.
    - In Scenario 1, when selecting specifically for administrative cost and financial solvency, up to $240 million annual savings.
    - From $110 million to $150 million annual savings in other scenarios.

    - Root cause of most of the savings across two of the scenarios (estimated $135 million to $170 million) is the elimination of plans from two specific administratively inefficient national MCOs.
- Modest opportunity to expand average BH access, if BH network adequacy is used as a selection criterion (Scenario 3).
    - A slight decrease in the proportion of BH service networks that are deficient, from 17–20% to 14–17% of networks deficient in the average member's plan).
    - To improve beyond this, the state will need to require even average-performing plans to improve their current network adequacy and tackle deficiencies. In a procurement, NYS could ask specifically for how plans intend to improve BH access.
- Members and providers will be moving plans in the short term.
    - Up to 60% of members will change plans. However, those members will move to plans that meet higher standards.
    - Up to 30% of providers must recontract or will not be part of any MCO network. However, overall provider burden will decrease, and providers will contract with higher-performing plans.
    - There is potential to further integrate behavioral and physical health care through a procurement, which can benefit long-term member and provider experience.
- Members may have only one choice Upstate due to the elimination of low-performing plans, which may be mitigated through market adaptation (e.g., mergers) or procurement requirements for plans to expand their service areas.
    - In Scenarios 1 and 2, more than half of counties will go from roughly three to zero or one plan.
- Improvement in quality is achievable when quality used as a selection metric but implementing high quality standards eliminates some of the state's largest plans in the scenario.
- Reducing overall plan count and increasing enrollment per plan will likely improve cost, provider burden, and oversight.
    - Reduction from 12 plans to three to seven plans (~40%–75% decrease) in each scenario and an increase in average plan size from 0.1–0.5 million to 0.2–1.9 million members, depending on the region.

The data underlying the points above are visualized in the table below, which color-codes the range of impact of procurement based on whether it is a substantial benefit or risk statewide or regionally.

Exhibit 11.2:	Mainstream Procurement Scenario Range of Impact
Data source:	Scenarios Analysis (see Scenarios Methodology)

Impact measured	Metric	Range of impact (statewide)	Range of impact (regional)		
			NYC metro	East/central	West
Statewide fragmentation	Total # of plans in the market	3-7 plans			
Fragmentation: Plan choice	Average number of plans per county		6.3 to 2.3-4.3 plans per county	2.7 to 0.4-1.7 plans per county	3.5 to 0.05-1.8 plans per county
Fragmentation: Plan choice	# of 0- or 1-plan counties	19-54 of 58 counties	Remain at 0 of 4 counties	Increase from 2 to 14-35 of 35 counties	Increase to 2 to 5-19 of 19 counties
Fragmentation: Sub-scale plans	Avg plan scale in region		0.5M to 0.8-1.3M members per plan	0.2 to 0.3-1.0M members per plan	0.1 to 0.2-0.7M members per plan
Admin cost	Annual savings	Up to $110-$240M in annual savings			
Member impact	Number of members that are forced to change plans due to their plan being eliminated	1.2-3.4M (20-60%) of members move plans	0.7-2.0M (20-65% of) members move plans	0.2-0.9M (25-90% of) members move plans	0.3-0.7M (45-90% of) members move plans
Provider impact	Number of providers that may recontract due to all their plans being eliminated	9-38K (5-30%) of providers must recontract	5-18K (5-20%) of providers must recontract	3-12K (10-45%) of providers must recontract	2-15K (10-75%) of providers must recontract
Provider access	Weighted avg. % of BH service deficiencies per county		17% to 10-18%	19% to 17-47%	20% to 17-12%
Quality	% of members in high-quality plans	From 62% to 22-100% of members in quality plans			

Benefit of a procurement | Minor risk or potential benefit/risk depending on scenario | Risk-procurement implementation should specifically address | More extreme risk-procurement implementation should specifically address

Key Findings: Root Causes of Low Upstate Plan Choice in MLTC

Every scenario modeled in MLTC results in either zero or one plan in certain counties Upstate. This violates CMS's choice guidance, which requires members to have at least two managed care plans to choose from.[71]

The reason every scenario results in low upstate plan choice is that the scenarios eliminate two plans, one focused in West NY and one in East/Central NY. Both plans are rated one star on quality, unprofitable, and have minimal alignment with MAP or Medicare D-SNPs. Eliminating these two plans leaves members in 24 counties with only one plan.

Key Findings: Root Causes of High Savings Potential in Mainstream

All Mainstream scenarios show a substantial improvement to administrative costs, even though not all the scenarios select on cost.

Two plans have the state's highest percentages of their revenue spent on administration (ALR), shown as Plan A and B in the table below. Both are eliminated in two of the three scenarios (cost and quality), and Plan A is eliminated in the third scenario (BH adequacy). The table below illustrates why eliminating these two plans could generate substantial administrative cost savings. Note that these calculations are meant to be directional only and may not correspond to previous budget estimates.

Exhibit 11.3: Opportunity Sizing from Eliminating Two Specific Plans
Data source: MCO Financial Reports, 2019

	Plan's ALR		Other Plans' Median ALR		% saved		Annual Revenue[72]		Annual Savings
A	11.6%	-	8-8.5%	=	3-4%	x	$2B	=	$60-80M
B	13.9%	-	8-8.5%	=	5-6%	x	$1.5B	=	$75–90M

[71] Social Security Sec. 1932. [42 U.S.C. 1396 u-2] (a)(3)(A). Contains a rural exception that may be in effect in some of the counties but has additional associated requirements [See Sec. 1932 (a)(3)(B)].
[72] Includes any plans thereafter acquired.

Total									**$135–170M**

This $135–$170 million represents most of the savings projected in Scenarios 1 and 2, and the $60–$80 million associated with Plan A represents most of the savings forecasted in Scenario 3.

Implications

Taken together, the scenarios highlight a series of opportunity and risks associated with procurement. These opportunities and risks are also present when raising certification standards, but the risks are easier to mitigate in a procurement (see Section 10).

Top Opportunities

The primary benefit of a procurement is the ability to increase standards and select the highest-performing plans, thereby improving overall market performance. Feasible impacts depend on state priorities but include:

- Putting every member in a high-quality plan (MLTC and Mainstream).
- Up to $300 million in annual administrative cost savings (combined across MLTC and Mainstream), without accounting for potential additional administrative cost savings through economies of scale as remaining plans expand membership
- Full alignment between long-term care and physical health benefits for dual-eligible members (MLTC).
- Reduced market fragmentation (MLTC and Mainstream), leaving 11 to 18 plans in MLTC (a 25%–50% reduction) and three to seven plans in Mainstream/HARP (bringing Mainstream/HARP in line with benchmarks). This is expected to drive improvement across many state goals (see Section 6).
- Modest improvement in behavioral health access (Mainstream/HARP), increasing compliance with the state's mandated minimums and improving access for members.

Risks and Mitigation Strategies

If NYS raises certification standards or procures, it should implement mitigation strategies for two foreseeable near-term risks:

Risk 1: Any change to meaningfully raise standards on MCO performance will cause members and providers to switch to or re-contract with higher-performing plans.

- Procuring MLTC has projected member impact of up to 25% of members changing plans. Projected impact to members if Mainstream/HARP is procured is higher (up to 60% changing plans) in scenarios that eliminate low-performing large plans based on historical performance.
- Up to 20% of MLTC providers and up to 30% of Mainstream/HARP providers will have all their contracted plans eliminated and will need to re-contract based on scenarios modeled.

However, this risk is not necessarily cause for concern. Impact to members and providers is common in peer procurements, is manageable by the state, would likely be smaller than modeled in this analysis, and is in the long-term interest of the members and providers.

- Impact common in peer procurements: MLTC member impact is in line with peer states assessed, which see 20–30% of members change plans during a procurement. Some Mainstream

scenarios result in member impact in line with this benchmark, while some have a higher member impact.

- Impact manageable by the state: NYS already has contractual provisions to mitigate member disruption in the event of plan termination, including requiring advance notice and mandating coverage for a designated period. In a procurement, the state can enforce these standards. In addition, CMS mandates readiness reviews to ensure MCOs can deliver services under their post-procurement obligations.[73]
- Impact likely smaller than modeled: Given that the analysis does not model market adaptation or state intervention (see the Limitations section), real impact will be somewhat different than listed above. Upon the state's announcement of a procurement system, the market is likely to respond to improve performance (e.g., through change processes and M&A), increasing the percentage of members and providers whose plans survive procurement.
- Impact drives long-term benefits: In a market with fewer plans that are held to higher standards, members and providers can ultimately benefit in the long-term through enhanced member/provider experience, higher quality, better health outcomes, and lower costs.

Risk 2: In both MLTC and Mainstream/HARP, many Upstate members are outside the service area of the highest-performing plans, meaning they could be left with fewer than two plans in their county as required by CMS.

- If NYS eliminates low-performing plans, the state needs high-performing plans to offer services Upstate. In crafting its RFP, the state could allow MCOs time to adapt to the new standards or require high-performing plans winning a procurement to expand their service areas.

Sensitivity of Opportunities and Risks to Criteria Chosen

The exact market impacts are highly dependent on the plan selection criteria chosen. For instance, requiring MLTC plans to have a Consumer Guide rating of 4+ stars instead of 3+ stars eliminates some of the state's largest plans and would result in many members moving plans. As mentioned above, in a procurement, the state can select a specific number of plans or balance the RFP with other standards to protect continuity of care. However, if the state were to raise certification standards *without* the flexibility a procurement affords, it would have to be careful to select criteria that are meaningful yet achievable to ensure an appropriate number of plans are certified.

Conclusions

Procurement can improve cost savings, especially in Mainstream/HARP, as well as alignment of care in MLTC, and quality of care in Mainstream/HARP and MLTC. It can also make modest improvements in BH access in Mainstream/HARP through selection on current plan network adequacy. These improvements are incremental to other benefits of market consolidation, including enhanced state oversight. Procurement also comes with risks: Members will move plans, providers will have to re-contract, and Upstate members may have few plans to choose from. However, risks to members and providers are routinely addressed by peer states, and plan choice can be protected by requiring bids in specific geographies (e.g., Upstate) to ensure high-performing plan coverage across the state. In a market with fewer plans that are held to higher standards, members and providers will ultimately benefit in the long-

[73] "Key federal program accountability requirements in Medicaid managed care," MACPAC, https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care/.

term through enhanced member/provider experience, higher quality, better health outcomes, and lower costs.

12 CONTRACT AND CONTRACT MANAGEMENT LEVERS

Background

This section of the report addresses the Legislature's request for "an evaluation of new performance standards or requirements that could be imposed upon Medicaid managed care organizations that participate in the managed care program pursuant to a contract with the department of health," as well as "an assessment of current mechanisms for enforcement of performance requirements, including but not limited to oversight of Medicaid managed care organizations and penalties."

Regardless of whether a state uses a certification or a procurement model, setting contract standards and enforcing them are integral parts of the process of improving MCO services. While certification or procurement selects the players in the market, the contract and management of the contract can ensure that MCOs live up to the standards or face consequences. States who use procurement often update their model contracts alongside the RFP to ensure that any promises made in an RFP are appropriately codified and become clear requirements. Expert interviews suggest states may find a need to procure to make significant contract changes that otherwise might be considered material and prohibited under state law without an RFP.

There are two parallel approaches to enhancing oversight of MCOs:

1. Changes to the model contract: achieving state goals by including clear requirements, incentive arrangements, and enforcement mechanisms in contracts.
2. Ongoing active contract management (ACM): driving MCO performance and accountability across goals by enforcing contract provisions and implementing proactive strategies.

DOH can only make limited updates to its model contract without also updating the public health law and regulations. The NYS model contract, which all MCOs must sign with DOH, is based on public health law and regulations. Public health law includes the requirements that MCOs need to meet to be certified. Regulations—written and promulgated by DOH—outline the ongoing rules and processes of monitoring and enforcing legislation that MCOs must comply with to continue certification. The model contract provides additional details and greater specificity, but ultimately it refers to the statute and the regulation, where the actual requirements live.

NYS's contract management approach currently consists of the following mechanisms:

- Ongoing surveillance and quality review, including comprehensive operational surveys (COS) conducted every two years, targeted operational surveys (corrective, in response to findings from the COS), and focused and ongoing review activities.
- Monthly meetings with all MCOs together, which cover MMC program updates, initiative specific updates, and guidance on policy and regulation.
- Citations and sanctions/penalties, defined in the statute, and the contract. If an MCO is found in violation, DOH first issues the MCO a statement of deficiency/findings and then a plan of correction, which the MCO can dispute. Performance is then monitored and assessed again through operational and focus surveys. If an MCO is found to repeat the same violation, then OHIP will move to enact sanctions in concert with the Division of Legal Affairs, such as financial penalties or plan enrollment penalties. While termination (decertification) is also a lever available to NYS, there is no recent record of NYS decertifying a plan.

Key Findings

Contract changes and active contract management must be pursued together. The contract must set clear, meaningful, member-centric, and enforceable standards. ACM must be in place to ensure that standards are reached and engender a data-driven culture of continuous improvement for both the state and its MCOs. Such an approach is difficult in NYS today due to the large number of overall plans to manage and the current resources available to conduct contract management and oversight.

Based on a comparison of current NYS standards with best practices across other states, NYS has the greatest potential opportunity to change and increase contract standards in quality, provider access, and clarity of enforcement mechanisms and penalties.

Quality: While the state has a quality incentive bonus program, it might benefit from moving MCOs to a quality withhold; this reserves part of the MCO payment until standards are reached. At least 12 other states are found to withhold a portion of capitation payment that MCOs can earn back if quality thresholds of performance are met, with the withhold ranging from 1% (Michigan) to 3.6% (California).

Provider access: Network adequacy standards—especially for behavioral health and LHCSAs—can be strengthened, particularly by incorporating new standards that measure access from a member perspective, such as time and distance standards, appointment availability, wait times, or staffing levels, in line with proposed new CMS guidelines. For example, in a survey of 39 states with Medicaid managed care, 28 had time and distance standards defined for mental/behavioral health, 14 had distinct standards for SUD treatment specifically, and seven had wait time standards for BH providers. Similarly, CMS's MLTSS Access Monitoring Toolkit recommends standards that not only measure the number of staff at each provider, but also consider the percent of time care managers spend on direct service.[74]

Enforcement mechanisms and penalties: Finally, regardless of current resources, the state's contract enforcement effectiveness is constrained by limited and unclear financial penalties and rules in public health law. Financial penalties are specified directly in public health law PBH § 12, which uses an inflexible $2,000 maximum fine per violation instead of referring to damage clauses in the contract. Further, lack of clarity on what constitutes a violation when applied to managed care deficiencies further creates confusion. Inadequate and unclear financial penalties may weaken MCO incentives for compliance and divert funds away from patient care. In contrast to NYS, California can adjust sanctions, ranging from $25,000 to over $400,000 per infraction. In 2022, California issued a record $55 million fee against its largest MCO for failing to provide adequate, timely care.

DOH would have a greater ability to pursue penalties if the public health law were clarified. The law could allow DOH to define penalties proportional to potential damages and articulate a clear process by which the state can assess penalties. These changes would reduce DOH's legal risk in assessing penalties and would streamline the enforcement process by clarifying the definition of a specific violation under the law or contract. Claims/encounter data penalties are already covered separately from the $2,000 maximum fine in the law, indicating that it is possible to vary penalties or potentially defer to the contract itself.

[74] "Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Service and Supports Access Monitoring Toolkit," CMS, June 2022.

Additionally, the statements of deficiencies and findings are not transparent to the public and could be communicated more straightforwardly to stakeholders.

To pursue ACM, the state should increase the frequency of its performance reviews outside formal surveillance activities. It is a best practice to launch monthly or quarterly data-driven MCO-specific meetings to transparently review progress on key performance measures. However, the state likely lacks the resources to perform such reviews given staff shortages in divisions responsible for managed care contracting and oversight, as well as the number of plans in the market.

Detailed findings on the benchmarking of, and opportunities for improvement in, contract standards and ACM best practices are covered below.

Detailed Findings: One-Time Changes to Contracts

We took the took the following steps to evaluate NYS's current MMC model contract standards and identify ways to optimize the contract:

- We selected high-priority topics across state goals for identifying and analyzing contracting best practices in other states.
- We researched and analyzed literature on MCO contract best practices across Medicaid programs with regard to prioritized topics.
- We examined states' model contracts to assess application of best practices.
- We reviewed current NYS MCO model contract provisions and compared them with best practices in other states, which were identified using other state contracts (cited in the Appendix) and publicly available literature (cited within Section 12).
- We identified NYS opportunities for improvement.

The following priority topics for benchmarking NYS's model contract against best practices were defined based on NYS goals for its Medicaid managed care program and the key challenges confronting it today, as detailed in this report.

Outcomes

1. Quality incentives
2. Provider access
3. Health equity
4. Social Determinants of Health (SDOH)

Member experience

5. Member disruption
6. Customer service

Provider experience

7. Reimbursement/billing accuracy and timeliness
8. Data sharing

Cost and value

9. Administrative costs and profitability
10. Value-Based Payment (VBP)

Accountability

11. Pre-certification review
12. Enforcement mechanisms and penalties

In the following section, we discuss NYS's current contract provisions for each of the 12 topics above, opportunities for improvement, and examples of best practices from other states.

1. Quality Incentives

NYS can better drive MCO performance by using quality withholds (downside risk) in Mainstream and MLTC and by improving the use of its auto-assignment (AA) incentive algorithm, primarily in MLTC.

Quality Withholds

- Current NYS standards: NYS does not have withhold arrangements for its Quality Incentive Program (QIP). Instead, NYS's QIP is structured as a bonus, with payments structured as performance-based capitation payments. NYS does have a quality withhold for the HARP program specifically; as of 2019, NYS withholds 2% of the premium for HARP plans as part of a behavioral health quality-incentive program.
- Opportunities for improvement: NYS can increase the effectiveness of its QIP by adding a capitation withhold beyond HARP, rather than relying only on a performance bonus. The state would withhold a designated percentage of the MCO's monthly capitation payment. Based on behavioral economics literature, downside risk can be particularly effective in driving change. For each measurement year, the MCO earns back the performance withhold based on its performance relative to incentive-based measures and targets as established by the state, such as a set of HEDIS or other quality measures.
- Best practice examples from other states:
    - At least 13 other states are found to withhold a portion of capitation payment that MCOs can earn back if quality thresholds of performance are met. These states, and their respective withholds, are California (3.6%), Oregon (3.5%), Texas (3.0%), Missouri (2.5%), Iowa (2.0%), Louisiana (2.0%), Ohio (2%), Washington (2.0%), New Mexico (1.5%), South Carolina (1.5%), Virginia (1.25%), Arizona (1.0%) and Michigan (1%).[75,76]
    - Ohio MCOs, for example, can recoup withheld payments if they improve their performance on a set of clinical quality metrics including completing well-child visits for pediatric populations, initiating substance-use treatment for members who have appropriate diagnoses, following-up with members after they are hospitalized for mental illness, and controlling diabetes and high blood pressure for enrolled members.[77]

Quality Informed AA Algorithm

- Current NYS standards: NYS categorizes MCOs into five tiers based on QIP scores. Only MCOs in tier five are penalized in terms of auto-assignment. However, only one MCO has been in tier five in recent years. Auto-assignment to MCOs in tiers one through four is fully randomized among

[75] "Key Considerations for Incentivizing Value-based Payment in Medicaid Managed Care Through Withhold Arrangements," Medicaid Innovation Accelerator Program, March 2021, https://www.medicaid.gov/resources-for-states/downloads/iap-vbp-key-consi-incent-medi-mngd-care.pdf.
[76] Justine Zayhowski et al., "Quality Incentive Program Design Decisions: An Overview of Programs in California and Selected Other States," February 2021, https://www.chcf.org/wp-content/uploads/2021/01/QualityIncentiveProgramDesignDecisionsOverview.pdf.
[77] "Improving Performance and Accountability," Ohio Department of Medicaid, https://medicaid.ohio.gov/about-us/budget/sustainability-quality-access/improving-performance-and-accountability#:~:text=Currently%2C%20Ohio%20Medicaid%20withholds%202,set%20of%20clinical%20quality%20metrics.

available plans, meaning that the algorithm does not reward higher quality with higher auto-assignment for the vast majority of its plans.

- Opportunities for improvement: NYS can more effectively utilize a quality-informed AA algorithm. While NYS's relatively low auto-assignment rate in Mainstream (~5%) compared to peers blunts the potential impact of this lever, it could be effective in other lines of business that have higher auto-assignment rates, such as MLTC (~37% auto-assignment).
- Best practice examples from other states:
    - California's auto-assignment incentive program rewards higher-performing plans with a greater percentage of enrollees based on eight performance measures related to quality, access, and timeliness of care.

2. Provider Access

NYS's network adequacy and provider access standards for primary care are in line with benchmarks. However, NYS's standards for BH lag other states, and there is significant opportunity to augment contractual requirements, particularly given current BH provider access gaps. Additionally, NYS has room to improve network adequacy standards in MLTC. For both BH and MLTC, NYS can incorporate additional standards that are more indicative of true provider access, such as requirements around time and distance, member-to-provider ratios, appointment availability, and provider activity in treating Medicaid patients. NYS can look to adopt forthcoming CMS guidance on access and can further innovate through the adoption of ACA exchange standards, which are stricter than Medicaid's.

BH Standards

- Current NYS standards:
    - Provider/service minimums: NYS stipulates 17 categories of BH services (e.g., Assertive Community Treatment, substance abuse treatment services) for which Mainstream and HARP plans must have at least two service providers per county for urban counties and two per region for rural counties. Additionally, HARP MCOs must meet similar provider minimums for 12 HCBS services.
    - Time and distance standards: Mainstream and HARP require maximum time and distance standards (from a member's residence to an available participating provider) of 30 minutes by public transit in metro areas and 30 minutes or 30 miles by public transit or car in non-metro areas. Some rural areas may exceed requirements if justified. In general, these standards do not apply to the BH services. However, if the plan cannot meet the aforementioned "two service providers" per county/region due to lack of provider supply, then the plan can satisfy the network adequacy standard by contracting surrounding county providers within 30 minutes/30 miles.
    - Member-to-provider ratios**:** NYS does not stipulate member-to-provider ratios for BH providers, but there are population-based caseload ratios for certain specialists, including 15.4 psychiatrists per 100,000 population. However, this standard is not actively enforced. Eighty-eight percent of counties currently fail this standard.
    - Appointment wait times: NYS does not have standards for BH appointment access.
- Opportunities for improvement: Given current challenges with BH provider access, NYS could enact additional standards for BH service providers, such as time and distance standards, member-to-provider ratios, maximum appointment wait times, and higher provider minimums per county, particularly in rural areas. The recently proposed CMS rule specifically calls out appointment wait times as a critical measure and would require states to use "secret shoppers"

to measure compliance. Furthermore, given that nearly half (43%) of contracted BH providers did not bill for a single Medicaid patient in the past year, NYS could consider monitoring and establishing guidelines for Medicaid activity rates. Lastly, NYS should enforce its existing standards, including sanctioning noncompliance, to hold plans accountable to maintaining adequate access.

- Best practice examples from other states:
    - Provider minimums: The ACA stipulates that plans are required to have a certain number and geographic distribution of Essential Community Providers (ECP), who serve predominately low-income and medically underserved individuals.[78]
    - Time and distance standards: Among 39 states with Medicaid managed care surveyed in a study, 26 states (72%) had time and distance standards defined for mental/behavioral health (with maximum travel time averaging ~40 minutes in urban areas and ~60 minutes in rural areas), and 13 states (37%) had distinct standards for SUD treatment.[79]
    - Member-to-provider ratios: Of 39 states with Medicaid managed care surveyed, three had member-to-provider ratios for BH providers (ranging 100:1 to 1,500:1) and four had them for SUD providers (ranging from 200:1 to 10,000:1).[80]
    - Appointment wait times: 17 states have limits for maximum wait times for an appointment (by specialist) and seven states have wait time standards specifically for BH providers.

MLTC Standards

- NYS current standards: A minimum of two providers per county is required for most MLTC services. For LHCSAs specifically, MLTC plans must contract with a minimum of two LHCSAs per county while also abiding by a maximum LHCSA-per-enrollee ratio (1:100 for Downstate, 1:60 for Upstate).
- Opportunities for improvement: As discussed in Section 6, existing MLTC network adequacy standards for LHCSAs do not account for whether LHCSAs are servicing Medicaid patients, the size or availability of the LHCSA workforce, nor the time and distance from the LHCSA workforce to members. While no examples were identified in other states, NYS has the opportunity to be market-leading and improve timely access for MLTC members by establishing such standards.
- Best practice examples from other states:
    - Virginia requires MLTSS plans to offer members a choice of at least two providers.

Primary Care Standards

- NYS current standards:
    - Provider minimums: Public health law requires that members be allowed a choice of at least three geographically accessible primary care providers (PCPs).
    - Member-to-provider ratios: The maximum member-to-provider ratios stipulated for PCPs are 1,500:1 for single physicians, 2,400:1 for a physician acting combination with a registered physician assistant or a certified nurse practitioner, or 1,000:1 for a nurse practitioner practicing as a primary care physician. NYS's member-to-provider ratio standards assume PCPs are full-time (40-hours) with a single contracted plan. However,

[78] 45 CFR 156.235.
[79] Jane M. Zhu, MD, MPP, MSHP, and Daniel Polsky, PhD, MPP, "Variation in Network Adequacy Standards in Medicaid Managed Care," AJMC, June 9, 2022, https://www.ajmc.com/view/variation-in-network-adequacy-standards-in-medicaid-managed-care.
[80] Ibid.

in practice, 80% of PCPs contract with three or more plans and may see non-Medicaid patients.
    - Time and distance: As noted in the BH standard section above, NYS has time and distance standards for participating providers, which includes PCPs.
    - Providers accepting new patients: NYS does not currently have a requirement for PCPs to be accepting new patients and the state does not currently monitor whether contracted PCPs are actively seeing Medicaid patients.
- Opportunities for improvement:
    - NYS's standards for PCPs already follow best practice, stipulating provider minimums, member-to-provider ratios, and time and distance standards that are in line with benchmarks. Additionally, compliance with existing standards is already high, and over 90% of PCPs are billing for Medicaid patients based on an analysis of claims data. Therefore, any changes to primary care standards are of lower priority than improving BH and MLTC standards. However, NYS could still improve its standards by adjusting its assumption that PCPs are full-time with a single plan and by looking to adopt more stringent ACA standards, particularly around validating and publishing which providers are accepting new patients.
- Best practice examples from other states:
    - Providers accepting new patients: Connecticut requires 70% of providers to be actively accepting new patients. ACA exchange standards require plans to list which providers are taking new patients and to validate this information every 90 days.[81]
    - Member-to-provider ratios: Among 39 states with Medicaid managed care surveyed, 12 (31%) had member-to-PCP ratios, ranging from 250:1 to 2,500:1.[82]
    - Time and distance standards: 35 of 39 states with MMC surveyed had time and distance standards for PCPs, ranging from 15 to 90 minutes, with an average of ~45 minutes in rural areas and ~30 minutes in urban areas. Meanwhile, ACA exchange time and distance standards for PCPs are more stringent than typical Medicaid standards.[83]

3. Health Equity

While NYS addresses health equity in its 2022 proposed 1115 waiver and in VBP arrangements, it could build on these efforts by contractually requiring MCOs to invest in health equity—such as through equity-focused quality improvement projects, staffing and training, and strategic planning and reporting. NYS could also reward MCOs for outcomes in specific demographics. Plus, NYS could integrate equity goals into its QIP.

- NYS current standards: NYS requires MCOs to develop and execute a cultural competency plan and training curriculum based on Culturally and Linguistically Appropriate Services (CLAS).
- Opportunities for improvement: NYS should consider adopting new equity provisions in its contract, such as requiring performance-improvement projects with an equity focus, requiring MCOs to staff health equity roles, providing financial incentives to promote health equity, and mandating health equity reporting and annual planning.
- Best practice examples from other states:

[81] 45 CFR § 156.230 (b); US §9820 (2).
[82] Jane M. Zhu, MD, MPP, MSHP, and Daniel Polsky, PhD, MPP, "Variation in Network Adequacy Standards in Medicaid Managed Care," AJMC, June 9, 2022, https://www.ajmc.com/view/variation-in-network-adequacy-standards-in-medicaid-managed-care.
[83] CMS, "2023 letter to issuers in the federally facilitated exchanges," January 7, 2022, https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf.

- Ohio's contract requires that MCOs design and conduct improvement projects in clinical and non-clinical areas that improve population health and health equity across the care continuum.
- California's contract requires that MCOs train staff in health equity and submit a health disparities or health equity report to the state.
- Pennsylvania, as part of the MCO P4P program, has a health equity incentive program aimed at reducing racial health disparities for Black members using five specific quality measures (e.g., timeliness of prenatal care and postpartum care). California, Michigan, and Ohio are among other states with financial health equity incentives.
- Delaware requires MCOs to implement a Cultural Competence and Health Equity Plan, covering topics such as how data will be used to assess health equity needs and what policies are in place to ensure culturally competent care, and it requires that the plan be overseen by a designated executive employee.

4. Social Determinants of Health (SDOH)

To better address SDOH and improve person-centered care delivery, NYS could mandate in its contract that MCOs reinvest in their communities and perform SDOH screenings and assessments of new members.

Community Reinvestment

- NYS current standards: NYS's model contract does not require MCOs to reinvest in the local community. However, the DOH FY 2024 Article VII Proposal Form requires MLTC MCOs to present a plan to do so.
- Opportunities for improvement: NYS could mandate in contracts that MCOs spend a percentage of their net income (e.g., 5%–7.5%), profits, or reserves on community reinvestment.
- Best practice examples from other states:
  - Arizona, California, and Ohio require MCOs to dedicate a percentage of their annual income to community reinvestments.[84]

SDOH Screening

- NYS current standards: NYS's contract requires MCOs to conduct a new enrollee health screening that assesses special health, language, or communications needs, but it does not require an SDOH screening specifically.
- Opportunity for improvement: NYS could require in its contracts that MCOs perform SDOH assessment within 60–90 days of when a member joins a plan, with social-needs assessment and follow-up expectations clearly defined in the contract. Requirements in these areas should be linked to implementation of the 1115 waiver, pending CMS approval at the time of this report.
- Best practice examples from other states:

[84] "Addressing Health-Related Social Needs Through Medicaid Managed Care," State Health & Value Strategies and Health Foundation of South Florida, October 2022, https://www.shvs.org/wp-content/uploads/2022/11/Addressing-HRSN-Through-Medicaid-Managed-Care_October-2022.pdf. For example, California model contract: "Contractor shall demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment…"

- California introduced new contract provisions as part of its 2022 procurement linked to its CalAIM strategy that require MCO care managers to screen for SDOH, refer individuals to community health workers or community-based services to address identified needs, and track referrals to ensure fulfillment.
- Pennsylvania's contract includes a definition of SDOH and requires MCOs to use SDOH screening to determine members in need of care or case management.[85]

5. Member Disruption

NYS is following best practices with its current provisions to minimize member disruption from plan termination, including requiring advance notice and continued coverage for a designated period. In the event of a procurement, the state can ensure that these provisions are enforceable.

- NYS current standards: NYS requires 90-day written notice of plan termination by either the state or the plan and that, prior to contract termination, contractors make plans for the orderly transition of members. NYS specifies a 90- (Mainstream) to 120-day (MLTC) coverage period for members to maintain continuity of care if they are seeing certain providers for services.
- Opportunities for improvement: NYS's contractual mechanisms to limit member disruption from plan termination are in line with best practice. The state should proactively enforce these requirements in the event of a procurement.
- Best practice examples from other states:
  - Wisconsin requires a 90-day notice for plan termination. If all members are not transitioned by a given date, the MCO must continue operations until all members are transitioned. MCOs must also develop a transition plan and designate a transition coordinator.
  - Pennsylvania requires that members actively receiving care from an MCO that was not selected in its procurement process continue receiving care for up to 60 days after transitioning to a new MCO.

6. Customer Service

NYS can look to tighten its existing customer service standards, particularly since Mainstream plans slightly underperform the national average on CAHPS member satisfaction scores. Although NYS already awards plans based on customer service and member experience measures in its QIP, it could increase downside risk for plans not meeting thresholds by adding a capitation withhold. Furthermore, NYS could incorporate call center performance measures into contracts.

Financial Incentives

- NYS current standards: As part of its QIP, NYS awards points to MCOs if they score above the statewide average on three CAHPS measures. MCOs that meet these thresholds may be given a performance bonus.
- Opportunities for improvement: NYS can add a capitation withhold for performance on these measures to increase downside risk.
- Best practice examples from other states:

- Michigan withholds a portion of capitation payments that MCOs can earn back by meeting quality thresholds, including for customer service, based on CAHPS scores.
- California places 10% of its participation fee for covered California plans (ACA) at risk. In its 2020 contract, 15% of this at-risk amount was related to the customer service areas of abandonment rate, service level, implementation of appeals decisions, grievance resolution, and resolution of member inquiries. Based on how a plan performs, it can receive a performance penalty, no penalty, or a performance credit.

Call Center Performance Metrics

- NYS current standards: NYS has staffing requirements for MCO Member Services Departments but does require specific call center performance metrics.
- Opportunities for improvement: NYS can incorporate call center performance metrics into contracts, such as call response time and abandonment rate, to enhance customer service.
- Best practice examples from other states:
  - Pennsylvania mandates that MCO member hotlines be staffed appropriately so at least 85% of calls are answered within 30 seconds and no more than 5% of calls are abandoned.

7. Reimbursement/Billing Accuracy and Timeliness

Reimbursement/billing is a major pain point for providers, representing 60% of formal provider complaints submitted to the state. To improve accuracy and timeliness of claims reimbursement, NYS could shorten prompt pay deadlines or increase financial penalties for late payments in line with benchmarks. The state can also look to enforce these standards with more rigor and speed. For example, fines for inappropriate claims denials from 2017 to 2021 were not posted until 2023.

- NYS current standards: NYS mandates that clean claims must be paid within 30 days if submitted electronically and 45 days if submitted by paper[86] and charges 12% annual interest on clean claims that are paid late.[87]
- Opportunities for improvement: NYS can consider shortening its clean claim submission window (e.g., other states require 15 days) and/or charging higher interest for late claims (e.g., other states charge 15–18%).
- Best practice examples from other states:
  - California mandates that MCOs pay 90% of all clean claims within 30 days of submission and 99% of all clean claims within 90 days of submission, with 15% annual interest charged on clean claims paid late.
  - Ohio previously mandated that MCOs pay 90% of all clean claims within 15 days of submission and 99% of all clean claims within 90 days of submission for BH claims. For other claims, it mandated that MCOs pay 90% of all clean claims within 30 days of submission and 99% within 90 days. The state charges 18% annual interest on clean claims paid late.

8. Data Sharing

[86] NY Insurance Law §3224-a (a).
[87] NY Insurance Law §3224-a (c) (1).

To address current gaps in physical and behavioral health provider integration and care coordination, NYS should consider instituting a comprehensive data sharing agreement between MCOs and providers.

- NYS current standards: NYS requires that MCOs share data with certain providers and care-management entities, such as Health Homes.
- Opportunities for improvement: NYS could extend its data-sharing agreement to all provider types and create a statewide data exchange. This would enhance care coordination between physical and behavioral health providers across the care continuum.
- Best practice examples from other states:
    - California mandates that MCOs participate in its data-sharing agreement, a statewide data exchange among various types of health care organizations, including payers and providers.[88]
    - Pennsylvania mandates that MCOs share with providers data on high-risk, high-volume utilizers the provider serves in the VBP contract and claims and utilization data across the care continuum.

9. Administrative Costs and Profitability

NYS's contract standards for controlling administrative costs are already strong, with a higher Medical Loss Ratio (MLR) minimum than other states, meaning that plans must spend less on administrative activities. From a profitability perspective, the state could add a one-sided profit cap to retain excess revenues, particularly in MLTC, where plan profits are higher.

Administrative Costs

- NYS current standards: NYS sets the MLR minimum at 89% in MLTC Partial, Mainstream, and HARP,[89] but the model contract permits the state to set a higher MLR requirement as needed.
- Opportunities for improvement: NYS's standards already exceed benchmarks. However, NYS's low administrative cost provides an opportunity to become a market leader in minimum MLR. Given that the average administrative cost is 8.3% in Mainstream and 5.7% in MLTC, plans should be able to operate with a 1–2%+ underwriting ratio even if the state raised the minimum MLR to 90%. Raising the MLR could encourage plans to invest in expanding their networks and in provider compensation. It could also encourage the highest-ALR plans to become more efficient.
- Best practice examples from other states:
    - States must develop Medicaid capitation rates to achieve an MLR of at least 85%, but states are not required to set a minimum MLR for their managed care plans. Despite not being required federally, 37 states (of 41 with MMC) do set a minimum MLR for their MCOs.[90]
    - Massachusetts sets a minimum Mainstream MLR at 85%.
    - One other state currently has a 90% minimum MLR.[91]

[88] California Health and Safety Code § 130290.
[89] NYS OHIP.
[90] Elizabeth Hinton, Jada Raphael, and Kathleen Gifford, "Strategies to Manage Unwinding Uncertainty for Medicaid Managed Care Plans: Medical Loss Ratios, Risk Corridors, and Rate Amendments," KFF, April 10, 2023, https://www.kff.org/medicaid/issue-brief/strategies-to-manage-unwinding-uncertainty-for-medicaid-managed-care-plans-medical-loss-ratios-risk-corridors-and-rate-amendments/.
[91] Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets, HHS Office of the Inspector General, August 2021, https://oig.hhs.gov/oei/reports/OEI-03-20-00230.pdf. The specific state with a 90% MLR is not named in the report.

Profitability

- NYS current standards: NYS MLTC Partial has no permanent profit cap (though a risk corridor was utilized on a temporary basis during the COVID-19 pandemic).
- Opportunities for improvement: As discussed in Section 6, MLTC plan profitability varies widely, ranging as high as nearly $600 per member per month (versus up to only ~$22 PMPM in Mainstream). To retain excess profits in MLTC, NYS can consider instituting a profit cap.
- Best practice examples from other states:
    - Virginia Mainstream uses a one-sided profit cap to control excess profits.

10. Value-Based Payment (VBP)

To increase participation in VBP arrangements in MLTC, NYS can add a contractual requirement or target threshold VBP spend, as it already does for Mainstream plans. NYS can also increase the effectiveness of its current VBP requirements by tying VBP targets to withhold arrangements and increasing the specificity and standardization of VBP arrangements. However, some of the smaller MLTCP plans likely lack the ability to meet VBP requirements, given their size and capabilities.

VBP Spend Thresholds

- NYS current standards: NYS's contract requires Mainstream MCOs to include VBP arrangements in provider subcontracts and refers to the NYS VBP roadmap for specific minimum VBP goals. 80% of total MCO expenditures must be captured in at least Level 1 VBP arrangements, and 35% of total payments must be contracted through Level 2 VBP arrangements or higher. Plans are penalized 2% of the difference between the required level of VBP and their actual level of VBP. There is no VBP requirement or target threshold for MLTC plans.
- Opportunities for improvement: NYS should consider instituting a VBP requirement in MLTC and adding a withhold arrangement to existing VBP standards in Mainstream.
- Best practice examples from other states:
    - Ohio, New Mexico, and South Carolina require VBP payment targets (as a percentage of provider payments) and penalize MCOs for noncompliance through withhold arrangements.[92] For example, 20% of New Mexico's 1.5% capitation withhold and 25% of South Carolina's 1.5% capitation withhold are tied to VBP targets.

Specificity and Standardization of Arrangements

- NYS current standards: NYS defines "on-menu" options in its contract, with plan flexibility to define "off-menu" options subject to state approval.
- Opportunities for improvement: Plan flexibility in defining VBP arrangements has several shortcomings. First, it is harder for the state to enforce noncompliance. Second, providers may be burdened by multiple VBP contracts. And third, it is difficult to evaluate which models are working best. These issues likely outweigh potential MCO innovation stemming from VBP flexibility. NYS can increase the specificity and standardization of VBP arrangements, such as by pushing for MCO adoption of on-menu options. Specific definitions of levels of VBP tied to a

[92] State Strategies to Promote Value-Based Payment Through Medicaid Managed Care Final Report, MACPAC, March 13, 2020, https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf.

common framework such as HCP-LAN that can differentiate between provider- and non-provider-led plans would also help illustrate nuances in VBP approach among MCOs.

- Best practice examples from other states:
    - South Carolina has increased the level of standardization and detail required in MCO reporting on VBP spend. Initially, MCOs were only required to report overall VBP payments to determine if they met the target, but in 2019, the state began requiring more granular reporting based on standard categories defined by the Health Care Payment Learning and Action (LAN)'s Alternative Payment Model (APM) framework.[93]
    - Ohio requires MCOs to reconcile FFS payment to providers to a targeted spending amount for all services provided across specific episodes of care.

11. Pre-Certification Review

Strong MCO performance begins with robust standards for certification and admission to the market. However, NYS's certification process today, as laid out in public health law, is vague and discretionary compared to Maryland's.

- NYS's current standards:[94] NYS regulatory codes mandate specific leadership, financing, and conflict of interest disclosures. However, for fiscal solvency, access, and quality—key areas for improvement in the market today—no specific documentation is required in the statute. Furthermore, NYS regulatory codes do not require data reporting audits prior to certification.
- Opportunities for improvement: Given current challenges with plan profitability and access, as well as variability in quality of care, stronger pre-certification requirements could ensure fewer low-performing plans enter the market. However, given the number of established market players, improvements from this change are unlikely to quickly improve average performance unless decertification is pursued in parallel for noncompliant MCOs.
- Best practice examples from other states:[95]
    - Maryland's pre-certification review process has more specific legal requirements than NYS's. Maryland has specific requirements for currency reserves and reinsurance and requires network preapproval, NCQA accreditation, and a review of data compliance capabilities prior to certification.

12. Enforcement Mechanisms and Penalties

Contract standards are only meaningful insofar as they are enforced. DOH issues many citations with corrective actions against plans but comparatively few sanctions. NYS has the authority by law to impose sanctions, but contract and public health law language lacks specificity. To more effectively shape MCO performance, NYS can ensure contract language and public health law clearly define parameters for sanctions. NYS should also seek to tie more sanctions to specific contract provisions, rather than the rigid $2,000 maximum fines stipulated in public health law.

- NYS current standards: For the most part, MMC financial penalties are tethered to and specified directly in public health law, which uses an inflexible $2,000 maximum fine per infraction. A more flexible approach would be to refer to damage clauses in the contract. Having more

[93] Ibid.
[94] 10 NCRR 98-1.6.
[95] COMAR 10.67.03.

flexibility to tailor fines to specific violations could serve as an important signal to plans of the state's priorities. Claims data penalties are covered separately from the $2,000 maximum fine in the law, indicating that it is possible to vary penalties or potentially defer to the contract itself.

- Opportunities for improvement: Inadequate financial penalties may weaken MCO incentives for compliance and divert funds away from patient care. Clarity in public health law on potential damages and the process by which the state can assess penalties would reduce legal risk in this area and strengthen DOH's ability to pursue clear penalties for contract violations. It would also speed up the process of enforcement by clarifying what constitutes a specific violation under the law or contract.
- Best practice examples from other states:
    - California's sanctions range from $25,000 to $437,000 based on factors including number of members impacted and performance level in the current versus prior measurement year. In December 2022, California's Department of Health Care Services (DHCS) imposed $2.3 million in financial sanctions on 22 of the 25 MCOs it contracted with in 2021 for failing to meet minimum quality performance measures. California's Medicaid Director stated in a press release about the sanctions: "California continues to be a leader in improving how health care is delivered by setting a new standard. This enables us to hold our health plan partners accountable for providing person-centered and equity-focused care." Several months later, California issued a record $55 million fee against its largest MCO for failing to provide adequate, timely care.
    - Tennessee imposes liquidated damages for noncompliance related to approximately 70 metrics. Damages are grouped into three categories based on the level of threat posed by the violation. The dollar amounts of these liquidated damages range from $100 to $25,000 per occurrence per day.[96]

Detailed Findings—Ongoing Active Contract Management (ACM)

To improve MCO performance in line with state goals, any changes to NYS's contract described in the preceding section must be paired with a strong contract management approach to be effective.

This section explores DOH's current contract management approach and opportunities to improve it using a framework of four strategies for ACM.

Four ACM Strategies to Improve MCO Accountability and Performance

ACM is a framework, originating at the Harvard Kennedy School's Government Performance Lab, for improving collaborations between government agencies and social service providers to improve contracted services and achieve better results.

For simplicity, we have modified the framework to identify four key ACM strategies and associated best practices for MCO contract management:

1. Data-driven decision-making: Use high-frequency reviews of real-time performance data, actively interpret operational implications, and create feedback loops.
2. Collaborative culture: Encourage collaborative partnership with shared ownership, including regularly sharing data with MCOs and sharing case reviews and best practices in meetings.

[96] Randi Seigel, Anthony Fiori, and Thomasina Anane, "Insight: Strategies for Compliance Oversight and Program Integrity in Medicaid Managed Care," *Bloomberg Law*, August 15, 2018, https://news.bloomberglaw.com/health-law-and-business/insight-strategies-for-compliance-oversight-and-program-integrity-in-medicaid-managed-care.

3. Contract enforcement approach: Apply sanctions (financial or otherwise) to enforce contract provisions, follow through to ensure credibility, and publicize outcomes transparently.
4. Agency readiness: Hire to increase oversight resources, enhance capabilities and training, and ensure oversight staff are perceived as leaders responsible for a key part of the mission.

We evaluated NYS's current practices across these four strategies and benchmarked to other states to identify opportunities for improvement.

1. Data-Driven Decision-Making

NYS has multiple mechanisms to collect and evaluate data on MCO performance, including surveys conducted on a regular basis and on a targeted basis for corrective action. The state also regularly publically publishes its findings. However, OHIP does not have an in-house data analytics team, although it partners collaboratively with the Office of Quality and Patient Safety (OQPS) within DOH. Dedicating an analytics team to managed care could bring additional specificity and expertise to the work, freeing up OQPS analysts for other priority projects. Furthermore, the state's current reports are extensive, but difficult to digest. NYS could create a performance dashboard to increase transparency and better support decision-making for leaders and stakeholders. To execute these improvement efforts, NYS could leverage its External Quality Research Organization (EQROs).

<u>Current NYS practices:</u>

- NYS has three key mechanisms for gathering data for MCO oversight: ongoing surveillance and quality review, including comprehensive operational surveys; targeted operational surveys (corrective); and focused and ongoing review activities.
- DOH uses ongoing surveillance and quality review as its main MCO oversight tool. Comprehensive operational surveys (COS) are conducted every other year and incorporate pre-survey questions, document reviews, and onsite interviews with key staff.
    - Areas reviewed in these surveys include organization and management; member services/access to services; quality assurance; credentialing and re-credentialing; complaints and grievances; utilization; management information systems; provider networks; fraud and abuse; and Medicaid contract requirements.
- Targeted operational surveys address corrective actions taken in response to COS findings.
    - These surveys entail a review and evaluation of plans' changes to operational policies and procedures; implementation of its Plan of Correction (POC); recent complaints; and randomly selected provider contracts, among other areas.
- Focused and ongoing qualitative review activities are routinely conducted by NYS and/or its EQRO, as required by CMS.
    - Activities include access and availability studies; provider directory surveys; 1500:1 enrollee to PCP ratio survey; member services (secret shopper) survey; reviews of provider networks; financial reviews; reviews of complaints; fair hearings; and ad-hoc-focused surveys to test new procedures, benefits, or alleged impairments.
- NYS makes quality improvement oversight reports publicly available. It also issues detailed reports containing annual quality and health plan performance data, as well as records of citations and accepted corrective actions. These activities are led by roles within OHIP's Division of Health Plan Contracting and Oversight (DHPCO) and other offices, including but not limited to the Office of Quality and Patient Safety (OQPS) within DOH and DFRS.

<u>Opportunities for improvement:</u>

- **Dedicate an analytics team for high-frequency reviews of quality performance data:** DHPCO partners with the OQPS for data analytics and reporting; however, the division does not have a dedicated in-house analytics team. Creating a dedicated managed care analytics function could increase the frequency, depth, and breadth of analytics and reporting while also freeing up OQPS analysts for other priority projects.
- **Maintain analytical tools to monitor plan performance:** NYS's reports can be long and technical, and key information is spread across many discrete documents for individual health plans, making it difficult to draw insight. To more readily support decision-making, NYS can create and maintain a quality performance dashboard. The dashboard would be updated quarterly and include data on enrollment, utilization, appeals, grievances, network adequacy, and quality. The dashboard would need to be easily digestible to inform leadership decision-making.
- **Better utilize EQROs to support improvement efforts:** A recent MACPAC report[97] highlighted the extent to which states often rely on their federally mandated external vendors for reviews, particularly in quality. MACPAC further noted, as we have above, that technical report content can often be hard to absorb for interested stakeholders with "lengthy, highly technical reports, no consistent organization of findings, [and] rarely specified actions taken to address non-compliance." The report further found that "Stakeholders would like EQR process and findings to place more emphasis on outcomes and comparability." Integration of EQROs into an ACM practice, combined with improved oversight and guidance from CMS, could help NYS institute new, more meaningful reviews starting with existing resources.

Best practice examples from other states:

- California has a Managed Care Quality and Monitoring Division that maintains a public quality dashboard with clear data, providing greater transparency to inform decisions and enable more effective, efficient oversight. Its dedicated data analytics team sorts MCOs into tiers, based on detailed quality measures, to inform enforcement actions and the level of support DHCS will provide to an MCO.

2. Collaborative Culture

To establish more collaborative partnerships and shared ownership, OHIP could hold regular one-on-one meetings with MCOs and use these forums to share data and best practices.

Current NYS practices:

- OHIP holds monthly meetings with MCOs. These meetings are generally informative sessions in plenary, covering updates on programs and specific initiatives and guidance on policy and regulation.
- OHIP does not hold one-on-one meetings with MCOs outside of its surveillance and quality reviews.

Opportunities for improvement:

- **Hold one-on-one meetings and working sessions with MCOs:** OHIP could hold monthly or quarterly one-on-one meetings with plan leadership, as well as convene ad-hoc working groups

[97] Sean Dunbar, "Managed Care External Quality Review: Study Findings," MACPAC, March 2, 2023, https://www.macpac.gov/wp-content/uploads/2023/03/07_EQR-Findings-Slides-Final.pdf.

to address specific performance issues raised in those meetings. These could include work on specific performance-improvement goals.
- **Share data with MCOs:** OHIP could feature case reviews and best practices sharing in MCO meetings and regularly share state administrative data with MCOs.

Best practice examples from other states:

- Rhode Island's Medicaid Program facilitates monthly ACM meetings with leadership teams from its three MCOs.[98] Ad-hoc working groups, consisting of agency and provider staff, meet more frequently as needed to address specific performance issues raised in executive meetings. These meetings may be outside specific contract requirements but cover issues of importance related to state policy, members, or providers. For example, ACM meetings have been held specifically on claims denial rates for providers with ad-hoc analysis presented.
- Oregon actively works to foster partnerships between its Medicaid Coordinated Care Organizations (CCOs) and community-based organizations, particularly to address health equity and SDOH. The state helped to facilitate collaboration by providing written guidance and technical assistance, convening partners, and providing data that informed planning.[99]

3. Contract Enforcement Approach

As discussed previously, NYS issues many citations with corrective actions against plans but relatively few sanctions, including financial sanctions and enrollment sanctions, and there is no recent record of the state decertifying a plan. Citations alone are not a powerful enough enforcement mechanism.

To improve MCO compliance and performance, NYS should apply sanctions when justified and more transparently communicate the results of penalties and corrective actions to the public.

Current NYS practices:

- In cases of noncompliance, OHIP can use citations, sanctions, and termination (decertification) as available in statutes, regulations, and contracts.
- Citations provide detail on plans' deficiencies in meeting standards in the model contract or in obeying statutes or regulations. Over the past five years, NYS has issued over 174 behavioral health citations, which require a plan of correction from MCOs. These citations include:
    - 95 citations for violation of the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which requires MCOs to report results of payment and approval practices to prove that their mental health and substance-use disorders coverage is equivalent to that for medical/surgical. A 2022 survey found that several MCOs have repeatedly failed to demonstrate compliance.
    - 45 citations for inappropriate claims denials. DOH analyzes MCO processes for BH prior authorization and claims adjudication due to a high number of improper denials by MCOs that use vendors for claims adjudication, and citations are given for failure to conduct proper vendor oversight, improper denial of claims for prior authorization, and incorrect or late payment.

[98] Expert interview, February 2023.
[99] Neva Kaye, "Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health," National Academy for State Health Policy, February 5, 2021, https://nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health/.

    - 34 other citations. For example, MCOs must report changes to key BH staff to the state, and citations are given for failure to notify the state of such changes on the required timeline.
- There are several factors contributing to the state's limited use of sanctions.
    - First, as discussed in the preceding contract standard section, NYS's sanctions are tied to public health law, which lacks specificity and uses a broad-brush approach of a maximum $2,000 fine per violation. The lack of clarity about what constitutes a specific violation under the law or contract slows the enforcement process.
    - Second, the enforcement process is further slowed by limited state resources for oversight. For example, interviews suggest that a set of BH citations took over a year to be released at least in part due to staff bandwidth issues.
    - Third, the state has historically taken a low-confrontation approach, since penalties often lead to strong MCO pushback – or alternately because threats of sanctions alone, particularly related to enrollment, often yield behavior change. Interviews with stakeholders reinforced this notion that OHIP prefers to issue citations. OHIP rarely leverages sanctions for repeat offenses, and its fines are often neither timely nor substantial enough to adequately incentivize MCO compliance, given the plans' gains from noncompliance. No enrollment sanctions have been levied in recent years, though they have been threatened, according to interviews.
- Beyond its limited use of sanctions, there is no recent record of the state decertifying a plan, the strongest mechanism available to hold plans accountable to compliance and high performance. With the challenges posed by the number of plans in the market today, decertification or procurement is an important lever for state consideration.

<u>Opportunities for improvement:</u>

- **Apply sanctions to enforce contract quality performance provisions and tie corrective actions to further sanctions:** Citations alone are insufficient and should be paired with sanctions to more effectively enforce MCO compliance. While citations provide an ongoing mechanism for monitoring MCO contract and regulatory compliance and allow OHIP to work with MCOs to improve their operations, they do have several drawbacks. Citation documents can be lengthy and technical, and therefore not easily digestible. Plus, they are often focused on specific issues and may not track overall contract compliance. To provide more incentive for MCOs to change their behavior, NYS should increase the use of sanctions when warranted. While the threat of sanctions alone has, according to interviews, been an effective tactic to date, ultimately there needs to be follow-through when justified to ensure credibility.
- **Publicize outcomes of penalties and corrective actions:** Statements of deficiencies and findings are not transparent to the public. Only citations and plans of correction (POCs) are posted, so there is also no transparency regarding the ultimate outcomes of POCs. Furthermore, as discussed above, existing documentation is difficult to digest. The state could more simply communicate summaries of penalties and corrective actions, as well as results, to stakeholders.

<u>Best practices from other states:</u>

- Under their contract with California's Department of Health Care Services (DHCS), MCOs are required to meet or exceed required quality and performance levels established by DHCS. California requires MCOs to submit corrective actions within two months of notice, and the following year's sanction is influenced by the plan's degree of improvement. As discussed previously, California has not shied away from using sanctions, issuing over $2 million in fines to

nearly every MCO in the market for failing to meet quality minimums in a single year and issuing a $55 million fee on its largest MCO alone several months later.

4. Agency Readiness

As with many agencies across the country, OHIP's Division of Health Plan Contracting and Oversight (DHPCO) faces challenges with recruitment and retention of staff. The division has numerous vacant roles. To improve agency readiness and enhance oversight on an ongoing basis, NYS can hire additional resources for ACM. The state can also communicate and elevate the organizational importance of key ACM roles. Regardless of staffing levels, state oversight is challenged by the number of plans in the market today. Procurement of high-performing plans, or decertification of low-performing ones, would further improve agency readiness by tightening the span of state oversight.

Current NYS practices:

- DHPCO is NYS's primary division for overseeing and enforcing MCO contracts.
    - DHPCO is comprised of eight subdivisions: Executive, the Bureau of Managed Care Fiscal Oversight, the Bureau of Managed Care Certification & Surveillance, the Bureau of Provider Enrollment Program Integrity & Systems, the Bureau of Program Implementation & Enrollment, the Bureau of Managed Long-Term Care, the Bureau of Consumer Services, and the Bureau of Business Process Improvement & System Integration.
- As of February 2023, approximately one-third of roles in the division were vacant.[100] Additional resources for ACM could help improve MCO compliance and performance.
    - For example, OHIP conducts biannual surveys for compliance in Mainstream, but in MLTC, they are behind the two-year goal due to resource constraints.

Opportunities for improvement:

- **Ensure adequate levels of oversight resources and FTEs in key ACM roles:** Achieving the reforms described above to improve ACM would require additional resources, especially given NYS's large number of plans and lines of business. NYS could hire additional full-time employees for oversight activities and deploy FTEs in key roles, such as data manager, contract manager/administrator, and legal positions.
- **Ensure oversight staff are perceived as responsible for driving the mission:** NYS could communicate within the organization that ACM's roles and responsibilities are a key part of the mission to improve MCO performance. Furthermore, NYS could look for ways to break down silos between contract oversight staff within DHPCO, as well as between DHPCO and the rest of the department. Greater cross-agency coordination would lead to improved information sharing.

Because of data limitations, comparisons to other states' levels of MMC oversight resourcing was not feasible.

Conclusions

States employ two levers to hold contractors to high standards: contract standards and active contract management. These levers are most effective when employed together. NYS can strengthen contract

[100] NYS DHPCO organizational chart, February 15, 2023.

language on quality, access, and enforcement penalties. NYS can also pursue active contract management by increasing reviews of plans, improving use and transparency of data, and shortening the cycle between review and action. To have the capacity to employ these measures, the state will need to significantly augment its oversight staff and/or reduce the number of plans overseen.

13 ACKNOWLEDGEMENTS

This report would not have been possible without the time, input, and data provided by NYS government agencies and stakeholders. This includes the NYS Office of Health Insurance Programs, NYS Office of Mental Health, NYS Office of Aging and Long-Term Care, NYS Office of Quality and Patient Safety, and the NYS Council for Community Behavioral Healthcare.

Thank you for your contributions to this report.

14 APPENDIX

Appendix Contents

This appendix consists of the following sections:

- ***14.1: Analysis Methodology Notes:*** Explanation of approach, assumptions, and limitations for key analyses conducted.
- ***14.2: Data Tables:*** Additional supporting data cited throughout the report.
- ***14.3: Glossary of Acronyms:*** List of acronyms used throughout the report.

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14.1 Methodology Notes

14.1.1 Lines of Business

Data utilized:

- Enrollment Data (see Section 5 for detail)

Lines of business/products assessed:

- N/A

Approach:

- N/A

Assumptions:

- Given >99% of enrollees are represented by the Mainstream, HARP, MLTCP, and MAP lines of business, information about those lines of business gives a representative view of the market and therefore are the only product lines assessed in this report.
- Three remaining lines of business, which are excluded from analysis in this report, together represent <1% of enrollment:
    - MLTC Program of All-Inclusive Care for the Elderly (PACE)
    - HIV SNP
    - Medicaid Advantage (different from MAP)

- Where they have similar relevant characteristics, the Mainstream and HARP lines of business are treated together, and the MLTCP and MAP lines of business are treated together. For example, there is a 99.6% overlap in Mainstream and HARP providers, so they are analyzed jointly in provider network analyses. Conversely, Mainstream and HARP have different enrollment processes, so they are analyzed separately in member enrollment analyses.
- If the legislature makes major changes to a line of business, they are likely to make similar changes to other lines of business with similar service offerings and participating plans.

14.1.2 Regionalization and Regional Focus

Data utilized:

- Enrollment data (see Section 5 for detail)

Lines of business/products assessed:

- Mainstream and HARP (together)
- MLTCP and MAP (together)

Approach:

- Examined service areas of each plan, combined across the lines of business above.
- Divided counties, partially in alignment with Regional Economic Development councils (REDC) regions[101] to minimize the number of plans that had service areas divided substantially across multiple regions.
- Assigned each plan a regional focus (NYC Metro, East/Central NY, West NY, or Whole) based on its distribution of members.
- Used regions to conduct analyses of market performance and challenges by regions.

Assumptions:

- Plans that had over 50% of members in one of the Upstate regions (East/Central NY or West NY) were assigned to that region.
- Given its higher overall Medicaid population, plans were assigned to NYC Metro only if they had both 80% of membership in NYC Metro and represented no more than 10% of the *total* membership of any other single region.
- The remaining plans were given the Whole regional focus.
- For instance, VNS is assigned to Whole because its enrollment in East/Central and West NY were more than 10% of the total membership in those regions, even though they represent less than 10% of VNS's statewide population.

The table below demonstrates how most plans can be categorized by a single regional focus using this regionalization.

Exhibit 14.1.1:	Regional Focus Assignment of MLTC Partial & MAP MCOs
Data source:	MCO Enrollment, 2022

	% of Enrollment			
Plan	**NYC Metro**	**East/Central**	**West**	**Regional Focus**

[101] https://artsnys.org/new-york-state-regional-economic-development-initiative/.

Aetna	100%	0%	0%	NYC Metro
AgeWell	100%	0%	0%	NYC Metro
ArchCare	98%	2%	0%	NYC Metro
Centers Plan for Healthy Living	97%	0%	3%	NYC Metro
Elderplan	95%	5%	0%	NYC Metro
Elderserve	100%	0%	0%	NYC Metro
Elderwood Health Plan	0%	0%	100%	West NY
EverCare	0%	100%	0%	East/Central NY
Extended MLTC	100%	0%	0%	NYC Metro
Fallon Health Weinberg	0%	0%	100%	West NY
Fidelis	54%	29%	16%	Whole
Hamaspik Choice	13%	87%	0%	East/Central NY
Healthfirst	100%	0%	0%	NYC Metro
HealthPlus	100%	0%	0%	NYC Metro
iCircle Care	0%	22%	78%	West NY
Integra	100%	0%	0%	NYC Metro
Kalos Health	0%	0%	100%	West NY
MetroPlus	100%	0%	0%	NYC Metro
Montefiore HMO	100%	0%	0%	NYC Metro
Prime Health Choice	0%	100%	0%	East/Central NY
Senior Network Health	0%	100%	0%	East/Central NY
Senior Whole Health	100%	0%	0%	NYC Metro
VillageCare Max	100%	0%	0%	NYC Metro
VNA Homecare Options	0%	58%	42%	East/Central NY
VNS	87%	8%	5%	Whole

Exhibit 14.1.2:	Regional Focus Assignment of Mainstream & HARP MCOs
Data source:	MCO Enrollment, 2022

Plan	**% of enrollment**			**Regional Focus**
	NYC Metro	**East/Central**	**West**	
CDPHP	0%	97%	3%	East/Central NY
Excellus	0%	13%	87%	West NY
Fidelis	51%	34%	16%	Whole
Healthfirst	99%	1%	0%	NYC Metro
HealthNow	0%	0%	100%	West NY
HealthPlus	99%	1%	0%	NYC Metro
HIP	100%	0%	0%	NYC Metro
Independent	0%	0%	100%	West NY
MetroPlus	100%	0%	0%	NYC Metro
Molina	69%	17%	14%	Whole
MVP	33%	54%	14%	East/Central NY
United	73%	19%	8%	Whole

Limitations:

- Although many plans play exclusively—or nearly so—in a single region, there is still some discrepancy between which plans have positive enrollment in a region and which plans are assigned as focused there. For instance, in MLTC, although NYC Metro has 17 plans, East/Central 12 plans, and West NY eight plans total with positive enrollment in July 2022, the number of plans with a focus in each region is smaller (16, 7, and 6 respectively, including VNS and Fidelis as a focus in every region). These different assignments are used in different parts of the report based on which makes most sense for the particular analysis.
    - For instance, the benchmarking analysis in MLTC cites the total number of plans with positive enrollment for comparability to benchmark states, since benchmark states' data did not distinguish between a plan with positive enrollment in a region and a plan focused there. However, other analyses (e.g., procurement scenarios) use the regional focus as it is a closer representation of a plan's true service area and of where a plan might be able to demonstrate a history of providing care in an RFP, if its line of business were procured regionally.

14.1.3 Market Composition Benchmarking

Data utilized:

- Enrollment by region and plans participating in each region, retrieved from each benchmark state's website, utilizing the last complete month's available data for each particular data point

Lines of business/products assessed:

- Mainstream and HARP (together)
- MLTCP and MAP (together)

Approach:

- Identified the state's most recent procurement regions.
    - For MD and NYS, the two certification states with county-level information, a regionalization was constructed based on the state geography and plan service areas.
    - No county-level information was available in NJ, meaning it was benchmarked as a single state region.
- Selected an urban region corresponding to each state's largest metropolitan area.
- Selected exurban region(s) for areas away from major metro areas.
- Where possible, used population and total Medicaid enrollment to select comparable regions to NYS's. In some instances, this was not possible; for example, most peer states did not have a city with comparable total Medicaid enrollment to NYC.
- Identified the total number of plans in each region and included only plans that provide MLTSS (MLTC benchmarking) or physical health benefits (Mainstream). Both Medicare-aligned and non-Medicare aligned plans were included where data was available.
    - In areas defined by a single procurement region, plans are typically contracted to serve across the region and therefore the number of plans per county is equal to total plans in region.
    - In other areas, the average across counties of plans serving that county was used as the number of plans per county metric.
- Calculated total members in a region from state enrollment data.
- Calculated members per plan as the quotient of the members in region and the total plans in the region.

- Where region- and plan-level data was available, the range of members per plan was reported.
- Plotted plans on axes of plans per county and members per plan, with high fragmentation defined as having a large number of plans and low average enrolment per plan.

Assumptions:

- Plans providing services to specific sub-populations were sometimes excluded depending on the market share represented by the population. For instance, plans providing service exclusively to youth under the purview of a state department of children and families were excluded since those plans did not meaningfully contribute to the average member's plan choice, but LTSS plans serving only seniors would be included because LTSS is utilized more by seniors than by other sub-populations.
- In peer states, if an MCO had multiple MLTSS plans in different lines of business, their enrollments were combined. For example, Illinois offers both an aligned MLTSS line of business (Medicare-Medicaid Alignment Initiative) and a non-aligned MLTSS line of business.
- Where there were multiple lines of business to be combined and one had regional data and the other did not, the regional distribution of one line of business was extrapolated to the other to get a total regional enrollment.

Limitations:

- Data was inconsistently available for different lines of business across states, and states have minor lines of business that provide LTSS (analogous to PACE or HIV SNP in NYS) that may not be accounted for in the benchmarking.
- Specialized BH plans were not benchmarked because the structure of the HARP model is not comparable to peer states.
- Data across states was drawn from a period during the COVID-19 PHE, and plan scale may decrease across all plans at the end of the PHE. Given that the month of the latest data varies by state, the increase in enrollment due to the PHE may vary across states.

14.1.4 Administrative Cost and Profitability

Data utilized (see Section 5 for detail):

- MCO financial reports
- Milliman MMC Financial Results

Lines of business/products assessed:

- Mainstream
- MLTCP

Approach:

- Used 2019 plan list, rather than the 2021–2022 plan list used in the rest of the report, to avoid COVID-19-related noise and impact to plan financials.
    - 15 Mainstream and 26 MLTC plans were in the market in 2019 (excludes a 16th Mainstream plan, Crystal Run, that left the market that year). Some of those plans were acquired by other players in 2020–2021, leaving the 12 Mainstream and 25 MLTC plans used in the rest of the report.
- Pulled ALR by plan, which was shown directly in the reports.

- Pulled profitability by plan, which was reported in the financial reports' premium income P&L PMPM.
- Designated plans as either profitable or unprofitable. A plan was considered unprofitable if its premium income P&L PMPM was less than 0.
- Weighted the averages by the plans' number of member-months of revenue (which is closely tied to enrollment).

Assumptions:

- Assumed 2019 data provides a more accurate representation of plans' financial performance due to the financial impact of COVID-19.
- Used premium income rather than net income for profitability because premium income excludes certain plan expenses (e.g., long-term investments) and only focuses on the direct cost and administration, making it a better metric for the plan's benefit from a member. While net income reflects plans' true P&L, it includes more noise.
- Affinity and Molina's 2020 merger means that the 2019 ALR for Molina is likely not representative of today's market. In some instances, the 2021 Molina ALR of 13.9% is used, and in some, the 2019 Molina ALR of 16.7% is used, depending on whether the data point is being used for a future projection (used 2021 data) or as a historical example (used 2019 data).

Limitations:

- 2019 financials may not accurately reflect current or potential future plan financial performance.

14.1.5 Member and Provider Complaints

Data utilized:

- Member and provider complaints (See Section 5 for detail)

Lines of business/products assessed:

- Mainstream
- MLTCP and MAP (together)
- Note: Given the low volume of complaints for HARP (fewer than 70 complaints between 2019 and 2021), HARP was not assessed.

Approach:

- Analyzed complaints collected via phone or email by the Department of Health's Bureau of Consumer Services or the Bureau of Managed Long-Term Care regarding any disputes or concerns with the services they have received through their MCO.
- The total number of complaints was analyzed by plan and complaint type.
    - Complaint topics were grouped into access, billing, coverage/denial, eligibility/enrollment, quality, reimbursement/billing, and other.
- Average complaint rate was calculated per thousand members and a range was determined for the overall market and for small and large plans.

Assumptions:

- Includes member complaints logged with contact type "other."

Limitations:

- Only complaints logged with the state were able to be analyzed, which may not be representative of all complaints. Complaints made to individual MCOs were not collected.

14.1.6 Auto-Assignment & Plan Changes

Data utilized:

- Newly eligible Member Enrollment Data (see Section 5 for detail)
- Plan Changes Data (see Section 5 for detail)

Lines of business/products assessed:

- MLTCP and MAP were analyzed both together and separately to assess patterns within MLTC overall and within each product given distinct enrollment processes (e.g., default enrollment in MAP for eligible MCOs).
- Mainstream and HARP were analyzed separately given different enrollment processes (e.g., the HARP model involves default enrollment into the same Mainstream MCO for HARP-eligible members, with a period of allowable opt-out or plan change).

Approach:

- Analyzed enrollment records from 2019 to 2021 by line of business and by region to assess how newly eligible members choose plans as a measure of informed member choice in the market.
    - Assigned each initial enrollment record as either 1) an affirmative selection or 2) an auto-assignment/default or passive enrollment. See assumptions below.
    - Calculated rates of affirmative selection versus auto-assignment/default or passive enrollment by line of business and by county, and then rolled up county averages to the region level by taking a weighted average by county enrollment size.
    - The calculation of the auto-assignment/default or passive enrollment rate in this report is different than the state's methodology. The state calculates the monthly auto-assignment rate within each county as the number of members enrolled with the "05" code for the previous three months in that county, divided by the total number of enrollments within the last three months for that county. The overall auto-assignment rate is then calculated utilizing a simple average of the auto-assignment rates across all counties (versus this report, which takes a weighted average by county enrollment) and months (versus this report, which does not take a three-month rolling average).
- Analyzed plan change data from 2019 to 2021 by line of business, region, and plan size to assess the rates and patterns by which members change plans, as a measure of member preference and experience in the market.
    - Calculated average plan change rates by region using same methodology as above.
    - Calculated annual net member inflow and outflow by plan and by plan size by subtracting total plan changes into the plan from plan changes out of the plan.

Assumptions:

- Based on documentation and feedback provided by OHIP, enrollment reason codes 02, 03, and 04 were defined as "affirmative selection." All other codes (01, 05, 06, 07, 08) were defined as "auto-assignment/default or passive enrollment." Definitions for these designations are below.
    - Affirmative selection: Members actively select and enroll in their plan of choice.
    - Auto-assignment: Members that are newly eligible for a Medicaid line of business are automatically placed into a plan if they do not actively select one by the deadline.

    - Passive enrollment: Members are transferred from one plan to another by the state. Transfer can be initiated for multiple reasons, including a change in eligibility (e.g., member moves from Mainstream to HARP).
    - Default enrollment: Mainstream and HARP members that become eligible for Medicare are automatically placed into the D-SNP under the same MCO as their current Mainstream or HARP (i.e., IB-Dual) plan if they do not require LTSS or into the MAP plan under the same MCO as their current plan if they do require LTSS. This is only applicable to members that are enrolled in plans approved for default enrollment within specified counties.
- Analysis excludes plan enrollments and changes due to acquisitions (e.g., members that changed plans to the acquiring company of their initial plan), as this is a market-driven change beyond members' control. The following acquisitions occurred during the period of data assessed and were thus excluded: Molina's 2021 acquisition of Affinity; Molina's 2020 acquisition of YourCare; Fidelis' 2020 acquisition of WellCare.
- Analysis of newly eligible member enrollment includes records for initial member enrollment, discontinuous member enrollment (i.e., member returns to Medicaid after more than one day of non-enrollment), and line of business changes (e.g., Mainstream to HARP). All other enrollment records, including plan changes, HARP opt-outs, and acquisition-driven enrollments are excluded.
- Analysis of plan changes includes records wherein a member changed from one plan to another within the same line of business. This includes the full scope of plan changes, i.e., within the first 90 days of initial enrollment, between 90 and 365 days of initial enrollment (lock-in period for Mainstream since 2019 and MLTC Partial since 2021), and 365+ after initial enrollment. This includes members that change plans within the same county and members that change plans and counties.
- Across lines of business, 98–100% of plan changes are from members that stayed within the same county, so members changing plans due to necessity when moving counties is not a significant contributor to overall plan changes. Therefore, a change into (or out of) a certain plan was assumed to be an indicator of member preference for (or against) that plan.
- Higher rates of member auto-assignment/default or passive enrollment in the market or in a region was assumed to be an indicator of potential member confusion or a lack of understanding of available plan options or other barriers to informed member choice.
- 2021 figures were reported unless stated otherwise to reflect the latest data.

Limitations:

- Enrollment code 01 ("enrollment override") is used for multiple reasons. As such, the analysis cannot distinguish between whether members with this code have been auto-assigned, passively enrolled, or default enrolled. Therefore, this code has been combined with enrollment codes 05, 07, and 08 into the categorization "auto-assignment/default or passive enrollment."
- Enrollment data from before 2019 was not analyzed. Based on dataset limitations, it is unknown whether members changed line of business or lost Medicaid eligibility prior to 2019. Thus, some records coded in our analysis as initial enrollments may be line of business changes or return enrollments. This likely has negligible impact to the analysis.
- Member-level data was not provided and thus not analyzed. The factors underlying member plan selection and plan changes are unknown. For example, an affirmative selection could be the result of a strong member preference for their selected plan, or it may be a "random" selection of the first plan listed in the system.

14.1.7 Provider Contracting & Billing

Data utilized:

- NYS Provider Network Data System (PNDS) (see Section 5 for detail)
- Aggregated Claims Data (see Section 5 for detail)

Lines of business/products assessed:

- MLTCP and MAP were analyzed separately because they have different networks of LHCSAs (509 LHCSAs contracted with both, 110 MLTCP-only, 12 MAP-only)
- Mainstream and HARP were combined in this analysis, given that they have 99.6% of the same providers. Mainstream's network is used for the data shown.

Approach:

- Examined the percentage of providers that contract with a given number of plans, overall and by region, as a measure of provider contracting burden.
- Examined the percentage of providers that bill to a given number of plans, overall and by region, as a measure of provider billing burden.
- For both analyses, used a cutoff of five or more plans as a metric for high burden. Given that peer states have an average of two to five total plans per region, providers in peer states are unlikely to have the burden of contracting or billing to five or more plans.
- For MLTC, only LHCSAs were analyzed. Medicare administers most of the physical health benefits for MAP members, nursing facilities are carved out, and the state does not track any metrics on provider experience in the consumer-directed program, leaving only the LHCSA benefit relevant for this assessment.

Assumptions:

- Assigned providers to a region based on the region with the most total unique address entries in the index.
- Used unique National Provider Identifier (NPI) codes to count providers.
- Except where stated otherwise, analyses included all NPI codes in the provider index, not only physicians.
- For MAP, only providers in counties with at least 100 MAP members based on 2022 enrollment data were included (NYC, Nassau, Westchester), leading to the exclusion of East/Central NY and West NY. Therefore, regional analysis was not conducted for MAP.

Limitations:

- Only analyzing LHCSAs may limit the generalizability of the MLTC analysis, as LHCSA provider burden may not be representative of other provider types.
- Some LHCSAs may have multiple unique NPIs, potentially leading to overstating the number of unique LHCSAs.
- Because of the lag of claims data availability and the desire to use the most recent data where possible, there is a timing mismatch between the claims data (April 2021 to March 2022) and the contracted provider data (February 2023). This may account for some plans having claims submitted for plans that they are not listed in the index as being contracted with.

14.1.8 Provider Specialty Tagging

Data utilized:

- PNDS Data Dictionary[102]

Lines of business/products assessed:

- Mainstream and HARP analyzed together, given the networks are 99.6% the same.
- MLTCP and MAP not analyzed—the only specialization analyzed was LHCSAs, which were explicitly tagged in state data.

Approach:

- Two provider types were analyzed: BH and MD/DO PCPs.
- Based on the PNDS Data Dictionary and input from the PNDS team, a provider (unique NPI code) was categorized as a BH provider or MD/DO PCP based on their Primary Designation, Provider Type, and Primary Specialty, captured in the table below.

Exhibit 14.1.3:	Provider Categorization into Specialties
Data source:	PNDS Data Dictionary

Specialty Category	**Primary Designation** *"PCP/Specialist tag"*	**Provider Type** *"Degree/Licensure"*	**Primary Specialty** *"Field of practice"*
PCP MD/DO	1 – PCP Only 3 – PCP and Specialist	01 – M.D. 12 – Doctor of Osteopathy	050 – Family Practice 060 – Internal Medicine 150 – Pediatrics 776 – General Practice
BH Provider	2 – Specialist 3 – PCP and Specialist	01 – M.D. 04 – Licensed Social Worker 05 – Ph.D. 12 – Doctor of Osteopathy 23 – Physician's Assistant 71 – Licensed Behavioral Analyst 78 – Certified Behavioral Analyst Assistant	28 – Applied Behavioral Analysis Provider 191 – Child Psychiatry 192 – Psychiatry 195 – Psychiatry & Neurology 750 – Methadone Maintenance 780 – Clinical Psychologist 781 – Social Worker

Assumptions:

- This definition of PCPs is stricter than is used by the state because it excludes nurse practitioners and ob-gyn practitioners. Since PCP networks are adequate under the stricter definition, they are adequate under the state's definition as well.
    - Nurse practitioners were categorized separately because they have a different member-to-provider ratio stipulated (1000:1 instead of 1500:1).
    - Ob-gyn practitioners were excluded because they can only function as PCPs under some circumstances.

Limitations:

[102] PNDS Data Dictionary, New York State Department of Health, https://www.health.ny.gov/health_care/managed_care/docs/dictionary.pdf.

- Doctors' information in the index may be out of date or they may be more or less specialized than indicated, meaning that the tagging may not be fully accurate for any individual doctor.

14.1.9 Provider Index Analysis

Data utilized:

- PNDS (see Section 5 for detail)
- Enrollment Data (see Section 5 for detail)

Lines of business/products assessed:

- Mainstream and HARP analyzed together, given the networks are 99.6% the same.
- MLTCP and MAP were analyzed separately because the networks have substantial differences.

Approach:

- Used PNDS provider index to calculate the count of unique LHCSAs (for MLTC) and all providers (for Mainstream/HARP) by line of business, county, and plan to assess compliance with network adequacy standards.
- For PCPs in Mainstream/HARP, a member-to-provider ratio was calculated to assess compliance with network adequacy standards.
    - Aggregated enrollment data by line of business, county, and plan.
    - Calculated member-to-provider ratio by dividing enrollment by the number of providers tagged as a PCP for each county, plan, and LOB combination.
    - Calculated weighted average (by plan size) was then taken across plan ratios to derive a county-level member-to-provider ratio for each LOB.
    - Plotted ratios by county and regional on a NYS map to analyze geographic variation.
- Member-provider ratios for BH providers not stipulated in NYS contract and thus not assessed.

Assumptions:

- Assumed providers practice at all locations they are listed with in the index.
- Used unique NPI codes to count providers and LHCSAs.
- In instances of slight variation in plan names between provider index and enrollment data, made assumptions to standardize plan names.
- For member-to-PCP ratios, data indicating whether a PCP is supported by a physician's assistant (indicating whether NYS's contractual maximum ratio is 1,500 or 2,400) was not available, so analysis compared all PCP MD/DOs against the standard of 1,500.

Limitations:

- Addresses listed in the provider index may not reflect all locations where providers actively accept or treat members. Conversely, providers may not actively accept or treat members at all locations they are listed with in the index.
- Some providers or LHCSAs may have multiple unique NPIs, potentially leading to overstating the number of unique providers or LHCSAs.
- For MTLC, only analyzed LHCSAs, which may limit the generalizability of the findings for access in MLTC broadly.
    - Access to personal care aids through the Consumer Directed Personal Assistance Program (CDPAP) is a part of the MLTCP benefit, but access data is not readily available

for personal choice because the member selects their own caregiver through a Fiscal Intermediary. Access to personal choice could therefore not be analyzed in this report.
    - Nursing facility stays longer than 90 days are carved out of MLTCP and therefore not assessed in this report.
    - Data was not available for this report to analyze the Medicare physical health network for MAP members.
    - LHCSAs for one MLTC plan (Integra) missing from the dataset, potentially due to acquisition by HealthPlus.
- Data on the scale of each provider and LHCSA (i.e., number of members served and the size of the workforce) was not available and therefore not measured, limiting the assessment of provider accessibility that members experience.
- There is a timing mismatch between the provider index (February 2023) and member enrollment data (July 2022), but this likely has negligible impact on the findings.

14.1.10 Claims Analysis

Data utilized:

- PNDS (see Section 5 for detail)
- Aggregated Claims Data (see Section 5 for detail)
- Health Affairs study: Avital B. Ludomirsky et al., "In Medicaid Managed Care Networks, Care Is Highly Concentrated Among a Small Percentage of Physicians," Health Affairs 41, No. 5, May 2022.

Lines of business/products assessed:

- Mainstream and HARP analyzed together, given the networks are 99.6% the same.
- MLTCP and MAP analyzed separately because the networks have substantial differences.

Approach:

- Analyzed one year of claims data to assess how many providers actively bill Medicaid patients to better understand true provider access that members experience.
    - Prepped claims data for comparison against provider index by mapping plan names and filtering out claims that did not match relevant lines of business, provider class, and provider type.
    - Joined claims data with provider index to assess total number of claims filed by each provider for unique combinations of NPI, line of business, and plan.
    - Stratified providers into classification of "active" and "ghost" (see assumptions below) and calculated the rate of ghost providers in the market by line of business.
- This approach largely replicates an analysis published by Health Affairs, cited above.

Assumptions:

- All claims relevant to analysis are marked with Claim Class of "Professional" or "Institutional," and Claim Type of "Practitioner" or "Home Health Agency—Personal Care."
- Assumed providers "active" if they filed at least one Medicaid claim for at least one of their contracted plans in the year assessed; otherwise, designated provider as "ghost."
- Providers found to be active in one plan were classified as an active provider in all of their contracted plans in that line of business.

- In instances of slight variation in plan names between provider index and claims data, made assumptions to standardize plan names.

Limitations:

- Only one year of claims data was assessed (which may not be representative of every year) and there is a timing mismatch between the provider index (February 2023) and claims data (April 2021 to March 2022). This was the most recent 12-month period of full claims data available due to a lag in claims data collection.
- The criteria to designate a provider as active represents a low bar for activity (only one claim in one contracted plan) and thus may overstate the number of active providers/LHCSAs and understate the number of ghost providers/LHCSAs.
- Not all claims mapped to the provider index for unique NPI, LOB, plan combinations. This may be due to out-of-network care (including out-of-network care provided during the PHE), the timing mismatch of the provider index versus the claims dataset, or continuity of care clauses that require providers to continue to service to members for a designated period of time after plan contract changes.

14.1.11 PCP Plan Contracting Rates

The methodology to assess how many plans PCPs contract with is identical to that in the preceding Provider Contracting and Billing section, except this analysis filtered to PCPs rather than all Mainstream/HARP providers. Member-to-provider ratios for PCPs assume plans are full-time (40 hours per week) with their contracted plans, but this analysis shows that most PCPs contract with multiple plans, meaning that compliance with the existing ratio standard may not accurately reflect true access that members experience.

14.1.12 BH Service Network Deficiencies

Data utilized:

- PNDS BH Network Reporting Data (see Section 5 for detail)
- OMH Provider Network Adequacy Summary Q4 2022, published February 2023 (see Section 5 for detail)
- Guidelines for MCO Service Delivery[103]

Lines of business/products assessed:

- Mainstream and HARP analyzed together, given the networks are 99.6% the same.

Exhibit 14.1.4:	BH Access Requirements Tested
Data source:	Guidelines for MCO Service Delivery Networks, Version 3.0

[103] Guidelines for MCO Service Delivery Networks, Version 3.0, NYS Department of Health, https://www.health.ny.gov/health_care/managed_care/docs/guidelines_for_mco_service_delivery_networks-v3.0.pdf

Category of service	Urban counties	Rural counties
Outpatient Mental Health Clinic	The higher of 50% of all licensed clinics or minimum of two per county	The higher of 50% of all licensed clinics or minimum of two per region
Outpatient Mental Health Clinic—State operated	All in county	All in region
Personalized Recovery Oriented Services (PROS); Intensive Psychiatric rehabilitation Treatment (IPRT); or Continuing day treatment	The higher of 50% of the total sites offering those three services, or minimum of two. Where there are PROS programs within the county or region, the MCO must contract with the PROS programs first to meet its minimum network requirement.	
Assertive Community Treatment (ACT)	Two per county	Two per region
Partial Hospitalization	Two per county	Two per region
Inpatient Psychiatric Services	Two per county	Two per region
Comprehensive Psychiatric Emergency Program (CPEP) and 9.39 ERs	Two per county	Two per region
Psychosocial Rehabilitation services (PSR)	The higher of 50% of all programs designated or minimum of two per county designated where available. *HARP only*	The higher of 50% of all programs designated or minimum of two per region designated where available. *HARP only*
Community Psychiatric Supports and Treatment (CPST)	The higher of 50% of all programs designated or minimum of two per county designated where available. *HARP only*	The higher of 50% of all programs designated or minimum of two per region designated where available. *HARP only*
Adult BH HCBS Community Psychiatric Supports and Treatment (CPST)	Two of each service type per county (as available) *HARP only*	
Adult BH HCBS Education Support Services		
Adult BH HCBS Family Support & Training		
Adult BH HCBS Habilitation		
Adult BH HCBS Intensive Supportive Employment		
Adult BH HCBS Ongoing Supported Employment		
Adult BH HCBS Peer Support		
Adult BH HCBS Pre-Vocational Services		
Adult BH HCBS Psychosocial Rehabilitation (PSR)		
Adult BH HCBS Transitional Employment		

Approach:

- Used dataset to determine whether adequacy standards were met by county and plan for each of 17 BH service network standards in the table above. A deficiency is defined as any instance of a plan failing to meet one of the BH network standards in a county.
- Filtered dataset to only counties with active networks for a given plan, based on a list provided by OMH. Therefore, counties that a plan has just entered or no longer operates in are excluded from the analysis.
- Calculated the percentage of networks that were inadequate across the state. A range of 14% (OMH analysis) to 24% (our independent analysis) is given in the report.
    - OMH's analysis calculates deficiencies based on the contractual standards of having at least two service providers in the county for urban counties or in a Regional Planning

Consortium (RPC) region for rural counites. The analysis may also apply additional plan-level exclusions based on specific MCO circumstances.
    - This report's analysis calculates deficiencies by analyzing treating urban and rural counties equivalently, meaning that all counties must have at least two service providers. This is because the RPC regions can be geographically expansive areas, so compliance with a standard of at least two service providers in the RPC region may significantly understate access for members. For instance, St. Lawrence County is considered compliant with a given plan in Assertive Community Treatment (ACT) because there are at least two providers in the Utica-Adirondack region. However, there are no ACT providers in the county, and the nearest county with a provider is Oneida county, which is up to a three-hour drive away.

Assumptions:

- For each plan, only includes counties for which they are designated as active (based on state-provided data). This assumption is made in both OMH's analysis and this report's analysis.
- Assumes a plan's network is deficient if it the "overall met" field in the dataset was designated as "no." This assumption is made in both OMH's analysis and this report's analysis.

Limitations:

- Given NYS's current network adequacy contract standards are relatively low, the percentage of deficient BH service networks likely understates access challenges members face.
- While several other BH network adequacy standards exist (e.g., standards stipulated by the Office of Alcohol and Substance Abuse Services), this analysis only examines the 17 BH standards used in OMH's PNDS Network Reports.

14.1.13 Mainstream Quality

Data utilized:

- NCQA HEDIS metrics (see Section 5 for detail)

Lines of business/products assessed:

- Mainstream

Approach:

- There are over 90 individual HEDIS metrics measured by NCQA, from which 13 representative metrics were selected to analyze and benchmark NYS plans against peer states.
- The report did not use all 90 metrics because states do not measure all 90 HEDIS metrics. For example, NYS uses 30 metrics in its quality incentive program, and not all of the 30 are HEDIS measures that are therefore comparable across states.
- The 13 metrics were selected considering four factors:
    - Used by NYS in its quality program
    - Covered by HEDIS to enable cross-state comparability
    - Used by Medicare to evaluate plans, triple weighted by Medicare in their quality program (specific to primary care), and/or used by other state quality programs
    - Represent populations and important services covered in Mainstream: hospital quality, children's health, maternity, primary care, mental health, and substance use

Assumptions:

- The 13 metrics selected are representative of plans' overall quality performance.

Limitations:

- Based on contractual agreements for use of the NCQA data, which prohibits publishing performance on individual metrics by state and by plan, NYS and peer state performance across metrics is shown as a national percentile range, not the percentage of actual values reached for that metric.

14.1.14 Member Satisfaction

Data utilized:

- NY Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores
- SPH Analytics report: At-A-Glance Report on 2021 Medicaid Adult CAHPS 5.1H, SPH Analytics. https://www.healthpartnersplans.com/media/100734242/2021-adult-medicaid-cahps-report.pdf.
- Sources for peer state benchmarks
    - California: "2021 CAHPS Medicaid Managed Care Survey Summary Report," Managed Care Quality and Monitoring Division, California Department of Health Care Services, March 2022. https://www.dhcs.ca.gov/Documents/MCQMD/2021-Medicaid-Managed-Care-Survey-Summary-Report.pdf.
    - Illinois: "HealthChoice Illinois External Quality Review Annual Report, State Fiscal Years 2020–2021," Illinois Department of Healthcare and Family Services Division of Medical Programs, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/il2021eqrtrf1.pdf.
    - Maryland: "State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations, Adult and Child Populations, 2021 CAHPS® 5.0H Member Experience Survey, Center for the Study of Services," https://www.medstarfamilychoice.com/-/media/project/mho/mfc/maryland-healthchoice-physicians/quality-assurance-and-monitoring-programs/cahps_-2021_state_of_maryland_executive_summary_report.pdf.
    - Michigan: "2021 Adult Medicaid Health Plan CAHPS® Report," Michigan Department of Health and Human Services, https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder43/Folder3/Folder143/Folder2/Folder243/Folder1/Folder343/2021_MI_CAHPS_Adult_Medicaid_Report_Final.pdf.
    - New Jersey: "Core Medicaid and MLTSS External Quality Review Annual Technical Report, 2021–2022 Reporting Cycle," New Jersey Department of Human Services, https://www.state.nj.us/humanservices/dmahs/news/2021_Core_Medicaid-MLTSS_Annual_Technical_Report.pdf.

Lines of business/products assessed:

- Mainstream

Approach:

- Evaluated NYS performance on CAHPS health plan rating and customer service rating, benchmarking the average across plans to the national average and to peer state averages, and assessing the variation in performance among NYS plans.
    - The Health Plan Rating is the percentage of customers surveys that rate a plan 8, 9, or 10 out of 10.
    - The Customer Service Rating is the percent of customers responding "usually" or "always" to receiving needed information and being treated with respect from the health plan's customer service.

Assumptions:

- Though the SPH Analytics report may not include scores from every Adult Managed Medicaid member who completed the survey nationally, it is assumed to match the NCQA benchmark given its large sample size.

Limitations:

- N/A

14.1.15 HARP Quality

Data utilized:

- NYS Quality Assurance Reporting Requirements (QARR) quality metrics

Lines of business/products assessed:

- HARP

Approach:

- Examined the 24 QARR metrics for which the payer is HARP and where performance data was available in both 2019 and 2021.
- Calculated percent change in the "Rate" column of QARR data from 2019 to 2021.
- Determined whether each metric improved (positive percent change for metrics that are better when higher or negative percent change for metrics that are better when lower).

Assumptions:

- N/A

Limitations:

- Weights all 24 metrics evenly, when not all metrics are equally important and some metrics may be related (e.g., follow-up after hospitalization for mental illness within seven days and follow-up after hospitalization for mental illness within 30 days).
- Does not account for the extent of improvement or deterioration in the metric.

14.1.16 Procurement Benchmarking

Data utilized:

- Press search of publicly available data (e.g., state websites, state RFPs, press releases, articles)
- Health Management Associates Weekly Roundups: https://hmais.healthmanagement.com/hma-weekly-roundup/

Lines of business/products assessed:

- Mainstream/physical health-focused products (includes BH in some instances)
- LTSS-focused products

Approach:

- Searched publicly available data to identify MMC procurements across the nation that involved either Mainstream, MLTSS, or both lines of business.
    - Excluded any procurements exclusively for a population that was not Mainstream or MLTSS such as lines of business providing coverage for foster children, Intellectual and Developmentally Disabled (IDD), and Aged, Blind, and Disabled (ABD).
    - Excluded procurements in states with MCC models that do not use traditional MCOs (e.g., Oregon, Alabama).
    - If a state had more than one procurement for the same line of business 2015–2023, only the most recent procurement was included, and it was coded as a re-procurement.
- Assessed publicly available data to determine the following data points across procurements:
    - Lines of business procured
    - Geographic scope (statewide, regional, both)
    - High-level goals
    - Status (31 completed, three canceled, five in progress)
    - Date of RFP release, contracts awarded, and implementation
    - Number of bidders and number of awardees
- Calculated statistics across procurements.

Assumptions:

- Implementation dates that have not yet occurred are based on target dates communicated in the press.

Limitations:

- Publicly available information varies by state as each state has a unique program design and RFP process. Not all data points (e.g., number of bidders) were available for every procurement.
- Given that only states' most recent procurement was included, analysis is not inclusive of every completed procurement since 2015.

14.1.17 Procurement Case Studies

Data utilized:

- California:
    - California Releases Medi-Cal RFP for Two-Plan, GMC, Regional Models, HMA, February 17, 2022, https://www.healthmanagement.com/blog/california-releases-medi-cal-rfp-for-two-plan-gmc-regional-models/.
    - California's Resolve Questioned After It Grants Medi-Cal Contract Concessions, KFF Health News, January 27, 2023, https://kffhealthnews.org/news/article/californias-resolve-questioned-after-it-grants-medi-cal-contract-concessions/.
    - California Revises Medicaid Contract Awards, Adding 2 Insurers, Healthcare Dive, January 4, 2023, https://www.healthcaredive.com/news/California-MediCal-Medicaid-contracts/639580/.

- Lawsuits, Challenges and Debates: Where California's Controversial Medicaid Contract Process Stands, Becker's Payer Issues, October 17, 2022, https://www.beckerspayer.com/payer/lawsuits-challenges-and-debates-where-californias-controversial-medicaid-contract-process-stands.html.
- Joint Statement on the 2024 Medi-Cal Managed Care Plan Contracts, https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2022/22-18-Joint-Statement-on-the-2024-Medi-Cal-Managed-Care-Plan-12-30-22.pdf.
- Stakes Are High in California's Medicaid Market Shakeup, Healthcare Dive, December 21, 2022, https://www.healthcaredive.com/news/Medi-Cal-California-Medicaid-appeal/639052/.

- Indiana:
  - Award Recommendations, Indiana Department of Administration, https://www.in.gov/idoa/procurement/award-recommendations/.
  - Indiana Releases MLTSS RFP, HMA, July 14, 2022, https://www.healthmanagement.com/blog/indiana-releases-mltss-rfp/.
- Ohio:
  - Carrie Ghose, "Five insurers shut out of Ohio Medicaid file protests," *Columbus Business Journal*, April 17, 2012, https://www.bizjournals.com/columbus/blog/2012/04/five-insurers-shut-out-of-ohio.html.
  - Kaitlin Schroeder, "State rejects protest to new Ohio Medicaid System," *Dayton Daily News*, June 18, 2021, https://www.daytondailynews.com/local/challengers-protest-to-new-ohio-medicaid-system-denied/3H3CESPQSVEK7PICQHNC6NLWLE/.
  - Ohio's Managed Care Overhaul Delayed—New Implementation Timeline, BMD, May 4, 2022, https://www.bmdllc.com/resources/blog/ohio-s-managed-care-overhaul-delayed-new-implementation-timeline/.
  - Managed Care Procurement Award, Ohio Department of Medicaid, https://medicaid.ohio.gov/wps/wcm/connect/gov/09ebd9ee-6c80-4e37-b86f-5cc70858e58c/04-09-21-Ohio-Medicaid-MCO-Award-Selection-Brief-FINAL.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-09ebd9ee-6c80-4e37-b86f-5cc70858e58c-nCeKfFB.
  - Managed Care Procurement Award, Ohio Department of Medicaid, https://medicaid.ohio.gov/wps/wcm/connect/gov/09ebd9ee-6c80-4e37-b86f-5cc70858e58c/04-09-21-Ohio-Medicaid-MCO-Award-Selection-Brief-FINAL.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-09ebd9ee-6c80-4e37-b86f-5cc70858e58c-nCeKfFB.
  - Rebecca Pifer, "Centene awarded Ohio Medicaid contract following $88M settlement," Healthcare Dive, August 17, 2021, https://www.healthcaredive.com/news/centene-awarded-ohio-medicaid-contract-following-88m-settlement/605104/.
  - Request for Applications: Ohio Medicaid Managed Care Organizations, https://procure.ohio.gov/static/pdf/ODMR20210024930202011535 5ODMR20210024.pdf.
  - Titus Wu, "Toledo-based Paramount Advantage loses court fight to Ohio Medicaid over lucrative contract," *The Columbus Dispatch*, November 10, 2021, https://www.dispatch.com/story/news/politics/courts/2021/11/10/paramount-advantage-sues-loses-ohio-medicaid-over-contracts-toledo-corcoran-procurement-health-care/6351690001/
- Pennsylvania:

- Anna Catherman, "Plan selection period of new Medicaid Physical HealthChoices announced," The Progress, June 22, 2022, https://www.theprogressnews.com/news/state/plan-selection-period-of-new-medicaid-physical-healthchoices-announced/article_78b21950-f253-11ec-b6a7-2763c2280910.html.
- Commonwealth of Pennsylvania Department of Human Services, 2018 External Quality Review Report, Statewide Medicaid Managed Care Annual Report, May 2019, https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/2018%20-%20Statewide.pdf.
- Harold Brubaker, "Aetna, three others appeal long-term care loss in Pennsylvania, Philadelphia Inquirer, September 20, 2016, https://www.thegazette.com/health-care-medicine/aetna-three-others-appeal-long-term-care-loss-in-pennsylvania/.
- HealthChoices Toolkit, June 2022, https://www.dhs.pa.gov/HealthChoices/Documents/toolkit/HealthChoices%20Toolkit.pdf.
- PA RFA, Kyle Fisher, "DHS Targets July Launch for HealthChoices Changes," Pennsylvania Health Law Projects, January 25, 2022, https://www.phlp.org/en/news/dhs-targets-july-launch-for-healthchoices-changes.

Approach:

- Of 31 completed procurements since 2015, selected five to evaluate through more detailed case studies, based on the following criteria:
  - Prioritized more recent procurements.
  - Prioritized states with populations of at least five million people and Medicaid enrollment of at least one million members for increased comparability to NYS.
  - Excluded re-procurements in which the market composition did not change (i.e., same incumbents re-awarded contracts in same regions, such as in Tennessee's and Indiana's recent Mainstream procurements).
  - Selected mix of MLTSS and Mainstream procurements.
- Based on above criteria, selected California Mainstream/LTC, Indiana MLTSS, Ohio Mainstream, Pennsylvania Mainstream, and Pennsylvania MLTSS.

Assumptions:

- N/A

Limitations:

- Publicly available information varies by state as each state has a unique program design and RFP process. Not all data points (e.g., number of bidders) were available for every procurement.
- Given focus on most recent procurements, legal challenges may not be entirely resolved.
- Quantifiable outcomes metrics (e.g., improvement in quality) to assess states' realization of stated procurement goals are limited, particularly given focus on recent procurements.

14.1.18 Procurement Scenarios

Data analyzed (see Section 5 for detail):

- Enrollment Data
- CAHPS Data

- NCQA HEDIS® quality metrics
- NYS Consumer Guide Plan Ratings
- NYS QARR Quality Metrics
- NYS PNDS
- PNDS BH Network Reporting Data
- MCO Aggregate Financial Reports
- Milliman MMC Financial Results

Lines of business/products assessed:

- Mainstream & HARP (together), utilizing primarily Mainstream performance
- MLTCP & MAP (together), utilizing primarily MLTCP performance

Approach:

- See Section 11 of the report for detailed explanation of approach.
- This analysis uses both raw data and calculated metrics as inputs for analysis. Where calculated metrics are used, the same methodology is used as elsewhere in the report.
    - Exception: A 2019 list of plans was used for the ALR analysis in Sections 6 and 7. The more recent 2021–2022 plan list was used here.
- Details on the metrics assessed are below

Exhibit 14.1.5:	Selected Output Scenario Metrics
Data source:	N/A *(methodological choice)*

Impact measured	Metric description	Goal is to make metric	Data source	Analyzed by	Underlying assumption
Statewide fragmentation	Total number of plans in the market	Lower	2022 Enrollment Data	Statewide	N/A
Fragmentation: Plan choice	Average number of plans per county	Lower, but at least two per CMS guidance	2022 Enrollment Data	Region	Plans play across counties, and all plans willing to enroll new members
Fragmentation: Plan choice	Number of counties where new plans must enter to avoid CMS plan choice violations (i.e., zero or one plan per county after plan eliminations)	Lower	2022 Enrollment Data	Statewide + region	Remaining plans may expand into these counties via acquisition of eliminated plans, state requirements for plan service areas, or other means
Fragmentation: Sub-scale plans	Average plan scale in region	Higher	2022 Enrollment Data	Region	Returns to scale occur primarily regionally
Admin cost	Annual savings: Difference in average admin cost PMPM between eliminated plans and kept plans, times the number of member-months shifted	Higher	2019 Cost Assessment	Statewide	No one-time costs Admin costs PMPM are not affected by member inflow

Impact measured	Metric description	Goal is to make metric	Data source	Analyzed by	Underlying assumption
Member impact	Number of members that change plans due to their plan being eliminated	Lower	2022 Enrollment Data	Statewide + region	No acquisitions; members shift manually
Provider impact	Number of providers that need to recontract due to all their plans being eliminated	Lower	2023 Provider Index	Statewide + region	No acquisitions; providers shift manually
Provider access *MLTC*	Number of counties with no active contracted LHCSAs	Lower	2023 Provider Index	Region	An adequate network has LHCSAs in every county
Quality *MLTC*	Enrollment weighted average of plan star rating	Higher	2019 NYS Consumer Guide	Statewide	Consumer Guide rating is best available quality metric for analysis (CMS aligned D-SNP rating unavailable for 16 plans)
Alignment of Care *MLTC*	Percentage of members enrolled in an MCO that offers a MAP plan	Higher	2022 Enrollment Data	Statewide	Partial plan members can switch to MAP if they want aligned care
Provider access *Mainstream*	Enrollment-weighted average percentage of BH service networks that are deficient	Lower	PNDS Network Summary	Region	Applies total percentage of deficiencies across counties to plan performance in all counties
Quality *Mainstream*	Percentage of members in high-quality plans (those with at least half of quality incentive metrics above statewide average)	Higher	2023 Provider Index	Statewide	N/A

Assumptions:

- Selection of scenarios
    - Lines of business pairs (MLTCP/MAP and Mainstream/HARP) are modeled together given any procurement scenario impacting one would impact the other. This is because:
        - All HARP MCOs also have Mainstream plans, and all MAP MCOs also have MLTC Partial plans.
        - Plans have similar networks between their HARP and Mainstream plans, and between their MAP and MLTC Partial plans.
        - Services provided through Medicaid are similar between HARP and Mainstream plans, and between MAP and MLTC Partial plans (most of the physical health services in MAP are provided through Medicare).
    - The lines of business are modeled "as-is," i.e., the analysis assumes no changes to the structure of managed care products in Medicaid.
- Data for scenarios
    - Member enrollment and provider contracts were combined across Mainstream/HARP and MLTCP/MAP to quantify member and provider impact for both products. For other

output metrics, data for Mainstream was used to evaluate Mainstream/HARP and data from MLTCP was used to evaluate MLTCP/MAP procurement.
    - Data utilized is from the latest data year for which it was available, except for 2019 cost and profit data to avoid noise from the financial impact of COVID-19, consistent with other analyses of financial data in this report, and 2019 data for MLTC quality (the latest year available for the MLTC Consumer Guide ratings is 2019).
    - See table of evaluation metrics above for metric-specific assumptions.
- Evaluation of scenarios
    - Plans' prior performance is assumed to determine future performance when evaluating whether a plan will be selected in the market and assessing forecasted post-procurement market performance. No projections or assumptions were made regarding plan adaptation to new requirements.
    - The "status quo" scenario assumes that the market will not change if the state takes no action. In reality, changes are observed over time in the market. For example, the Mainstream market has consolidated from 16 to 12 plans since 2018, with large plans purchasing small, unprofitable ones.
    - If a plan is eliminated in one region, it is assumed to be eliminated in every region it currently serves.
    - If a plan has minimal presence in a region, it is assumed it will not compete for procurement in that region. It is therefore excluded entirely from analysis of the region, and its members in that region are considered impacted (i.e., must change plans). Note that this applies to regional output metrics only, not statewide metrics.
    - It is assumed that members in eliminated plans enroll in plans remaining in the market proportionate to those plans' 2022 market shares.
    - It is assumed that all plans that meet the scenario criteria remain in the market, rather than selecting a target number of awardees as may be done in a procurement.
- Interpretations of scenarios
    - The scenarios ignore implementation challenges (e.g., delays, unforeseen external events, unexpected costs, second-order consequences of member/provider impact).

Limitations:

- See Section 11 of the report.

14.1.19 Model Contract Benchmarking

- Comparison of current NYS model contract standards against best practices to determine opportunities for improvement.

Data utilized:

- NYS model contract
    - MLTC: Managed Long Term Care Partial Capitation Contract, New York State Department of Health, 3rd ed., https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2022/docs/part_cap_amended_contract_3rd.pdf.
    - MAP: Medicaid Advantage Plus (MAP) Model Contract, 3rd ed., https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2022/docs/map_amended_model_contract_3rd.pdf.

    - Mainstream & HARP: Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract, New York State Department of Health, March 1, 2019, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.
- Other states' model contracts
    - California: Medi-Cal Managed Care Boilerplate Contracts, California Department of Health Care Services, https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
    - California: Medi-Cal Managed Care Boilerplate Contracts, California Department of Health Care Services, https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
    - Delaware: MCO Master Service Agreement, Delaware Health and Social Services, https://dhss.delaware.gov/dmma/files/mco_msa_2020.pdf.
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14.2 Supporting Data

Exhibit 14.2.1:	Report Region to County Crosswalk
Data source:	Enrollment Reports (This Report's Regionalization); NYS Website (RPC Regionalization)

County	Report Region	RPC Region	County	Report Region	RPC Region
Albany	East/Central	Northeast	St. Lawrence	East/Central	Utica-Adirondack
Cayuga	East/Central	Central	Sullivan	East/Central	Mid-Hudson
Chenango	East/Central	Central	Tompkins	East/Central	Central
Clinton	East/Central	Utica-Adirondack	Ulster	East/Central	Mid-Hudson
Columbia	East/Central	Central	Warren	East/Central	Northeast
Cortland	East/Central	Central	Washington	East/Central	Northeast
Delaware	East/Central	Central	New York City[104]	NYC Metro	New York City
Dutchess	East/Central	Mid-Hudson	Nassau	NYC Metro	Long Island
Essex	East/Central	Utica-Adirondack	Suffolk	NYC Metro	Long Island
Franklin	East/Central	Utica-Adirondack	Westchester	NYC Metro	Northern Metro
Fulton	East/Central	Northeast	Allegany	West	Finger Lakes
Greene	East/Central	Central	Broome	West	Finger Lakes
Hamilton	East/Central	Utica-Adirondack	Cattaraugus	West	Finger Lakes
Herkimer	East/Central	Utica-Adirondack	Chautauqua	West	Finger Lakes
Jefferson	East/Central	Utica-Adirondack	Chemung	West	Finger Lakes
Lewis	East/Central	Utica-Adirondack	Erie	West	Western
Madison	East/Central	Central	Genesee	West	Western
Montgomery	East/Central	Northeast	Livingston	West	Finger Lakes
Oneida	East/Central	Utica-Adirondack	Monroe	West	Western
Onondaga	East/Central	Central	Niagara	West	Western
Orange	East/Central	Mid-Hudson	Ontario	West	Finger Lakes
Oswego	East/Central	Utica-Adirondack	Orleans	West	Western
Otsego	East/Central	Central	Schuyler	West	Finger Lakes
Putnam	East/Central	Northern Metro	Seneca	West	Finger Lakes
Rensselaer	East/Central	Northeast	Steuben	West	Finger Lakes
Rockland	East/Central	Northern Metro	Tioga	West	Finger Lakes
Saratoga	East/Central	Northeast	Wayne	West	Finger Lakes
Schenectady	East/Central	Northeast	Wyoming	West	Western

[104] Consists of five counties but treated as one throughout the report due to the reporting level of enrollment data.

Schoharie	East/Central	Utica-Adirondack		Yates	West	Finger Lakes

Exhibit 14.2.2:	MLTC Fragmentation Benchmarking—Major Metro Areas
Data source:	Benchmark State Enrollment Reports, Procurement Regions, and Census Data, Latest Month Available

	NYC Metro	Philadelphia	Chicago	New Jersey	Los Angeles
Total Population (K)	12,383	4,195	5,173	9,267	9,830
Total Enrollment (K)	256	155	67	65	14
Total Plans in Rgn	17	3	6	5	2
Average Plans Available to Member in Region	13	3	4	5	2
Average Enrollment Per Plan in Region (K)	15	52	11	13	7
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	0.3-48	29-98	2-24	N/A	2-12

	San Diego	Columbus	Detroit	Milwaukee	Minn. St Paul (MN)
Total Population (K)	3,286	1,703	2,652	939	3,317
Total Enrollment (K)	1	13	33	11	41
Total Plans in Rgn	1	2	6	2	4
Average Plans Available to Member in Region	1	2	6	2	4
Average Enrollment Per Plan in Region (K)	1	7	5	5	10
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	1	6-7	3-12	4-7	4-18

Exhibit 14.2.3:	MLTC Fragmentation Benchmarking—Exurban Areas
Data source:	Benchmark State Enrollment Reports, Procurement Regions, and Census Data, Latest Month Available

	East/Central NY	West NY	PA Lehigh/ Capital	PA Northeast	Central IL
Total Population (K)	4,278	3,068	3,189	2,006	1,383
Total Enrollment (K)	15	12	79	59	20
Total Plans in Rgn	12	8	3	3	5
Average Plans Available to Member in Region	4	4	3	3	4
Average Enrollment Per Plan in Region (K)	1	2	26	20	4
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	0.030-5	1-30	18-36	14-25	1-12

	SW MI	N OH	NW OH	SW OH	S OH
Total Population (K)	844	604	43	2,555	1,703
Total Enrollment (K)	8	7	0.3	21	13
Total Plans in Rgn	2	2	2	3	2
Average Plans Available to Member in Region	2	2	2	2	2
Average Enrollment Per Plan in Region (K)	4	4	0.2	7	7

Range (Min and Max) of Enrollment Per Plan in Rgn (K)	3-5	3-4	0.1-0.2	5-10	6-7

	NE OH	NE Ctrl OH	MN–Ctrl	MN–North	MN–South
Total Population (K)	3,440	375	**700**	**737**	**953**
Total Enrollment (K)	35	3	8	11	12
Total Plans in Rgn	3	2	5	7	5
Average Plans Available to Member in Region	2.45	2	2.5	2.8	2.6
Average Enrollment Per Plan in Region (K)	12	2	2	2	2
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	6-18	1-2	1-3	0.02-4	1-4

	WI–Rgn 1	WI–Rgn 2	WI–Rgn 3	WI–Rgn 4	WI–Rgn 5
Total Population (K)	850	**850**	**652**	**860**	**1092**
Total Enrollment (K)	9	9	6	6	6
Total Plans in Rgn	2	2	3	3	3
Average Plans Available to Member in Region	1.7	2	3	3	2
Average Enrollment Per Plan in Region (K)	8	4	2	2	2
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	4-11	4.3-4.5	0.2-3	0.2-4	1-3

Exhibit 14.2.4: MLTC Partial Quality Performance Improvement Project (PIP) Metrics by Plan
Data source: NYS EQR 2021 Annual Technical Report (Published April 2023)

MLTC Partial plan	Percentage of Inpatient Discharges with Receipt of Discharge Information Within 10 Days	Percentage of Inpatient Discharges Which Resulted in Re-admission Within 30 Days Post-Discharge	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
Performance better if…	*Higher*	*Higher*	*Higher*	*Higher*	*Lower*
AgeWell	55.29%	7.19%			
Centers Plan	67.60%	19.80%			
EverCare	84.88%	23.68%			
Extended MLTC	81.50%	24.25%			
iCircle Care	100.00%	10.34%			
Integra	94.15%	14.62%			
Elderserve DBA RiverSpring	54.61%	24.10%			
Senior Network Health	82.14%	22.14%			
VNS Health	16.30%	11.10%			
Aetna			95.61%	89.58%	N/A
ArchCare			93.47%	86.65%	3.86
Elderplan			94.14%	86.32%	N/A
Elderwood			77.54%	80.51%	N/A
Empire BCBS HealthPlus			95.58%	91.88%	2.24
Fallon Health Weinburg			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			N/A	N/A	0.02
Montefiore HMO			69.41%	76.45%	3.98
VNA DBA Nascentia			86.34%	78.42%	4.52
Prime Health			89.21%	86.12%	5.38
Senior Health Partners Healthfirst			92.32%	80.57%	3.29
Senior Whole Health			93.64%	74.64%	2.86
VillageCare			95.65%	82.67%	2.74

Exhibit 14.2.5:	MLTC Partial Plans That Offer MAP; Does Not Include MLTCP Plans with No MAP Enrollment
Data source:	NYS Published Enrollment Reports, 2022

Plan Name	MLTCP Enrollment	MAP Enrollment	Total Enrollment	Product(s)	Plan Size
Centers Plan for Healthy Living	47,750	1,260	49,010	MLTC Partial & MAP	Large
Healthfirst	9,244	22,899	32,143	MLTC Partial & MAP	Large
VNS	22,142	3,090	25,232	MLTC Partial & MAP	Large
Fidelis	17,935	379	18,314	MLTC Partial & MAP	Large
Elderplan	14,797	3,051	17,848	MLTC Partial & MAP	Large
VillageCare Max	14,663	2,784	17,447	MLTC Partial & MAP	Large
Elderserve	15,401	118	15,519	MLTC Partial & MAP	Large
Senior Whole Health	13,951	134	14,085	MLTC Partial & MAP	Large
AgeWell	13,246	70	13,316	MLTC Partial & MAP	Large
HealthPlus	4,734	193	4,927	MLTC Partial & MAP	Small
Hamaspik Choice	1,962	359	2,321	MLTC Partial & MAP	Small
MetroPlus	1,305	20	1,325	MLTC Partial & MAP	Small
Total Enrollment	**177,130**	**34,357**	**211,487**		

Exhibit 14.2.6:	MLTC Partial & MAP Member Complaint Rates by Plan Size
Data source:	MLTC Complaints Data, 2021; Enrollment Data, 2022

Plan Name	Complaints per 1,000 members	Enrollment	Plan Size
Centers Plan for Healthy Living	2.69	49,010	Large
Integra	1.98	43,228	Large
Healthfirst	3.17	32,143	Large
VNS	9.23	25,232	Large
Fidelis	6.03	18,314	Large
Elderplan	3.26	17,848	Large
VillageCare Max	2.53	17,447	Large
Elderserve	1.89	15,519	Large
Senior Whole Health	2.47	14,085	Large
AgeWell	2.25	13,316	Large
Extended MLTC	1.33	5,483	Small
Aetna	2.85	5,399	Small
ArchCare	5.26	4,943	Small
HealthPlus	4.11	4,927	Small
iCircle Care	6.48	3,554	Small

VNA Homecare Options	5.48	3,524	Small
Hamaspik Choice	7.68	2,321	Small
Montefiore HMO	2.62	1,413	Small
MetroPlus	5.52	1,325	Small
Elderwood Health Plan	3.98	1,038	Small
EverCare	8.89	912	Small
Fallon Health Weinberg	0.00	849	Small
Kalos Health	18.84	553	Small
Prime Health Choice	4.90	549	Small
Senior Network Health	2.54	340	Small

Exhibit 14.2.7: Percent of Duals by Integration Level, All Lines of Business
Data source: NYS Dual Eligible Roadmap,[105] 2021

Medicare Placement	Medicaid MCO Percent Integrated	Medicaid FFS	MCO % of Total excluding FFS
Medicare D-SNP with Medicaid Contract Aligned	4%	0%	16%
Medicare D-SNP with Medicaid Contract Not Aligned	14%	21%	84% (of non-FFS D-SNPs aligned)
Medicare Advantage excluding D-SNPs	7%	11%	
Total–Excluding FFS	**25%**	**32%**	**100%**
Medicare FFS	13%	30%	-
Totals	38%	62%	-

Exhibit 14.2.8: MLTC Partial & MAP Consumer Guide Ratings by Plan, Region
Data source: MLTC Consumer Guide, 2019

Plan Name	Enrollment (2022)	Regional Focus	MLTCP Consumer Guide Rating	MAP Consumer Guide Rating
Centers Plan for Healthy Living	49,010	NYC Metro	5	No data
Integra	43,228	NYC Metro	3	No MAP plan
Healthfirst	32,143	NYC Metro	3	3
VNS	25,232	Whole	4	4
Fidelis	18,314	Whole	3	3
Elderplan	17,848	NYC Metro	5	5
VillageCare Max	17,447	NYC Metro	3	4
Elderserve	15,519	NYC Metro	5	No data
Senior Whole Health	14,085	NYC Metro	5	3
AgeWell	13,316	NYC Metro	2	No data
Extended MLTC	5,483	NYC Metro	4	No plan
Aetna	5,399	NYC Metro	3	No MAP plan
ArchCare	4,943	NYC Metro	3	No MAP plan
HealthPlus	4,927	NYC Metro	5	No data
iCircle Care	3,554	West	1	No MAP plan
VNA Homecare Options	3,524	East/Central	1	No MAP plan

[105] New York State Dual Eligible Integrated Care Roadmap, New York State Department of Health, March 2022, https://www.health.ny.gov/health_care/medicaid/redesign/duals/docs/2022_roadmap.pdf.

Hamaspik Choice	2,321	East/Central	4	No data
Montefiore HMO	1,413	NYC Metro	1	No MAP plan
MetroPlus	1,325	NYC Metro	3	No data
Elderwood Health Plan	1,038	West	2	No MAP plan
EverCare	912	East/Central	No data	No MAP plan
Fallon Health Weinberg	849	West	1	No MAP plan
Kalos Health	553	West	1	No MAP plan
Prime Health Choice	549	East/Central	4	No MAP plan
Senior Network Health	340	East/Central	4	No MAP plan

Exhibit 14.2.9: Mainstream Fragmentation Benchmarking—Major Metro Areas

Data source: Benchmark State Enrollment Reports, Procurement Regions, & Census Data, Latest Year Available

	NYC Metro	Los Angeles	New Jersey	Chicago	MD Balt-Wash
Total Population (K)	12383	9830	9267	5173	5175
Total Enrollment (K)	3808	3659	2142	1720	1223
Total Plans in Rgn	8	2	5	6	9
Average Plans Available to Member in Region	7	2	5	4	9
Average Enrollment Per Plan in Region (K)	476	1830	428	287	136
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	71-1252	1105-2554	N/A[106]	130-433	30-302

	Philadelphia	Detroit	San Diego	Columbus
Total Population (K)	4195	3922	3286	2359
Total Enrollment (K)	1024	990	912	582
Total Plans in Rgn	4	8	7	4
Average Plans Available to Member in Region	4	8	7	4
Average Enrollment Per Plan in Region (K)	256	124	130	146
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	97-534	29-231	28-330	66-317

Exhibit 14.2.10: Mainstream Fragmentation Benchmarking—Exurban Areas

Data source: Benchmark State Enrollment Reports, Procurement Regions, & Census Data

	East/ Ctrl NY	West NY	PA Lehigh-Capital	PA NE	CA Regional Model
Total Population (K)	4278	3068	3189	2006	1433
Total Enrollment (K)	1014	726	667	417	370
Total Plans in Rgn	8	8	5	3	3
Average Plans Available to Member in Region	3	4	5	3	2
Average Enrollment Per Plan in Region (K)	127	91	133	139	123

[106] New Jersey state enrollment reports did not include plan level data, and CMS data was observed as inconsistent with state reports in certain instances, so no range is reported for New Jersey.

Range (Min and Max) of Enrollment Per Plan in Rgn (K)	4-607	4-279	77-230	60-235	16-189

	Cent. IL	NE Lower MI	SE Ohio	MD Eastern Shore
Total Population (K)	1383	1071	825	459
Total Enrollment (K)	306	246	201	132
Total Plans in Rgn	4	4	4	6
Average Plans Available to Member in Region	3	4	4	6
Average Enrollment Per Plan in Region (K)	77	61	50	22
Range (Min and Max) of Enrollment Per Plan in Rgn (K)	49-110	24-85	25-85	4-83

Exhibit 14.2.11: Member Complaint Rates by Plan

Data source: DCS Member & Provider Complaints, 2021

Plan Name	Complaint Rate	Enrollment (2022)	Plan Size
Fidelis	0.06	1,743,428	Large
Healthfirst	0.11	1,239,856	Large
MetroPlus	0.05	475,295	Large
HealthPlus	0.13	392,156	Large
United	0.11	377,020	Large
Affinity	0.11	242,946	Large
Excellus	0.06	229,643	Small
MVP	0.07	209,522	Small
HIP	0.19	165,374	Small
CDPHP	0.13	112,057	Small
Molina	0.14	69,482	Small
Independent	0.06	69,450	Small
HealthNow	0.24	55,636	Small

Exhibit 14.2.12: Provider Complaint Rates by Plan

Data source: DCS Member & Provider Complaints, 2021

Plan Name	Complaint Rate	Enrollment (2022)	Plan Size
Fidelis	0.03	1,743,428	Large
Healthfirst	0.04	1,239,856	Large
MetroPlus	0.06	475,295	Large
HealthPlus	0.14	392,156	Large
United	0.15	377,020	Large
Affinity	0.13	242,946	Large
Excellus	0.03	229,643	Small
MVP	0.04	209,522	Small
HIP	0.26	165,374	Small
CDPHP	0.08	112,057	Small
Molina	0.07	69,482	Small
Independent	0.09	69,450	Small
HealthNow	0.02	55,636	Small

Exhibit 14.2.13: Underspending of Mainstream Behavioral Health Funds

Data source:	Behavioral Health Briefing Book (provided by OMH), SFY18-20

MMC Plan	SFY2018-19 BHET Remittance	SFY2019-20 BHET Remittance	Total
Healthfirst	$15,888,738	$10,683,923	$26,572,661
Fidelis	$0	$22,742,356	$22,742,356
HIP	$482,798	$17,114,588	$17,597,386
HealthPlus	$6,403,291	$7,434,430	$13,837,721
Molina	$1,750,770	$2,119,824	$3,870,594
MetroPlus	$2,503,388	$1,342,382	$3,845,770
VNS Choice	$2,292,443	$656,942	$2,949,385
Crystal Run	$103,719	$0	$103,719
Total	**$29,425,147**	**$62,094,445**	**$91,519,592**

Exhibit 14.2.14:	Underspending of HARP Behavioral Health Funds
Data source:	Behavioral Health Briefing Book (provided by OMH), SFY17–19

MMC Plan	SFY 2017–18 MLR Remittance	SFY 2018–19 MLR Remittance	Total
Fidelis	$40,336,664	$34,548,588	$74,885,252
United	$8,455,967	$16,747,438	$25,203,405
HealthPlus	$10,942,720	$4,372,237	$15,314,957
Affinity	$6,650,710	$8,317,445	$14,968,155
Molina	$0	$312,892	$312,892
Total	**$66,386,061**	**$64,298,600**	**$130,684,661**

Exhibit 14.2.15:	Mainstream & MLTSS Peer State Procurements, 2015–2022
Data source:	State Websites, healthmanagement.com, openminds.com, PHCA.org; 2015–2022

State	Program Name	LOBs Procured	Scope	RFP Date	Award Date	Implem-ent. Date	# of Bids	# of Awards
MI	Comprehensive Health Plan Contract	Mainstream	Regional	5/2015	10/2015	1/2016	13	11
MA	MCOs	Mainstream +LTSS	Statewide	12/2016	10/2017	3/2018	6	2
IL	Medicaid Managed Care Organization RFP	Mainstream +LTSS	Statewide, Regional	2/2017	8/2017	1/2018	13	6
PA	Community HealthChoices	MLTSS	Regional	3/2016	8/2016	2018-2020	14	3
AZ	Arizona Complete Care	Mainstream	Regional	11/2017	3/2018	10/2018	7	7
KY	Medicaid Managed Care	Mainstream	Statewide	1/2020	5/2020	10/2020	7	6
NC	Medicaid Managed Care Prepaid Health Plans (PHPs)	Mainstream	Statewide, Regional	8/2018	2/2019	11/2019	6	5
NH	New Hampshire Medicaid Care Management	Mainstream	Statewide	8/2018	2/2019	9/2019	4	3
KS	KanCare 2.0 Medicaid & CHIP	Mainstream	Statewide	11/2017	1/2019	7/2019	6	3

	Capitated Managed Care							
PA	Pennsylvania Physica HealthChoices	Mainstream	Regional	10/2019	7/2020	9/2022	8	6
WV	Mountain Health Trust	Mainstream	Statewide	12/2019	6/2020	7/2020	3	3
OH	Next Generation Managed Care Program	Mainstream	Regional	9/2020	4/2021	2/2023	11	7
DE	DSHP, DSHP Plus	Mainstream +LTSS	Statewide	12/2021	72022	1/2023	4	3
MS	MO HealthNet Managed Care Program	Mainstream	Statewide	11/2021	5/2022	7/2022	3	3
LA	Louisiana Medicaid Managed Care Organizations	Mainstream	Statewide	6/2021	2/2022	1/2023	6	5
NE	Medicaid Managed Care program	Mainstream	Statewide	4/2022	9/2022	1/2024	5	3
IA	Iowa Health Link	Mainstream +LTSS	Statewide	2/2022	8/2022	1/2023	5	2
MS	Mississippi-CAN, CHIP	Mainstream	Statewide	12/2021	8/2022	10/2022	5	3
DC	DCHFP, Alliance, ICP	Mainstream +LTSS	Statewide	11/2021	8/2022	1/2023	4	3
IN	MLTSS	MLTSS	Statewide	6/2022	3/2023	1/2024	7	4

Exhibit 14.2.16: MLTC Scenarios Output

Data source: Procurement Scenarios (see Methodology notes)

	Metric	Status Quo	Scenario 1	Scenario 2	Scenario 3
Statewide	# of plans remaining	25	11	18	12
	# of 0- or 1-plan counties	0	25/58	28/58	28/58
	# of counties with no active LHCSA	17/58	22/58	21/58	21/58
	Avg. state star rating of remaining plans	3.7	3.7	3.9	4.0
	Avg. CMS star rating aligned with remaining plans	3.8	3.8	3.9	3.6
	# of members who move plans	N/A	68K (24%)	24K (9%)	73K (26%)
	Avg. DSNP members per plan	13K	16K	18K	26K
	% of members in MCOs with a MAP offering	74%	76%	76%	100%
	% of LHCSAs with all contracted plans eliminated	N/A	127 (20%)	44 (7%)	62 (10%)
	Annual admin. cost savings	N/A	65M	(-17M)	(-25M)
Regional–NYC Metro	Avg. plan scale	16K	28K	18K	23K
	Avg. plan choice	12 plans	7.5 plans	10.5 plans	8.5 plans
	# of 0- and 1-plan counties	0/4	0/4	0/4	0/4
	# of counties with no active LHCSAs	0/4	0/4	0/4	0/4
	# of members who move plans	N/A	55K (22%)	15K (6%)	60K (24%)
	% of LHCSAs with all contracted plans eliminated	N/A	80 (17%)	11 (2%)	20 (4%)

Regional– East/ Central NY	Avg. plan scale	2K	7K	3K	5K
	Avg. plan choice	3 plans	1.7 plans	2.1 plans	1.8 plans
	# of 0- and 1-plan counties	0/35	12/35	12/35	12/35
	# of counties with no active LHCSAs	9/35	12/35	11/35	11/35
	# of members who move plans	N/A	8K (51%)	4K (26%)	6K (38%)
	% of LHCSAs with all contracted plans eliminated	N/A	32 (35%)	16 (18%)	25 (27%)
Regional– West NY	Avg. plan scale	2K	3K	6K	6K
	Avg. plan choice	2.8 plans	1.5 plans	1.1 plans	1.1 plans
	# of 0- and 1-plan counties	0/19	13/19	16/19	16/19
	# of counties with no active LHCSAs	8/19	10/19	10/19	10/19
	# of members who move plans	N/A	6K (50%)	8K (65%)	8K (65%)
	% of LHCSAs with all contracted plans eliminated	N/A	20 (32%)	25 (40%)	25 (40%)

Exhibit 14.2.17: Mainstream/HARP Scenarios Output

Data source: Procurement Scenarios (see Methodology Notes)

	Metric	Status Quo	Scenario 1	Scenario 2	Scenario 3
Statewide	# of plans remaining	12 plans	3 plans	5 plans	7 plans
	# of members who move plans	N/A	2.9M (52%)	3.4M (62%)	1.2M (22%)
	% of providers with all contracted plans eliminated	N/A	30K (23%)	38K (29%)	9K (7%)
	# of 0- or 1-plan counties	4/58	49/58	49/58	19/58
	Annual admin. cost savings	N/A	$240M	$125M	$110M
	% of members in plans with at least half of quality metrics scoring better than the current statewide average	62%	22%	100%	86%
Regional– NYC Metro	Avg. plan scale	0.5M members	1.3M members	1.3M members	0.8M members
	Avg. plan choice	6.3 plans	2.3 plans	2.3 plans	4.3 plans
	# of 0- and 1-plan counties	0/4	0/4	0/4	0/4
	# of members who move plans	N/A	2.0M (53%)	1.9M (50%)	0.7M (20%)
	% of providers with all contracted plans eliminated	N/A	18K (22%)	16K (20%)	5K (7%)
	Avg. % of deficiencies in BH networks	17%	18%	10%	14%
Regional– East/ Central NY	Avg. plan scale	0.2M members	1.0M members	1.0M members	0.3M members
	Avg. plan choice	2.7 plans	1 plan	0.4 plans	1.7 plans
	# of 0- and 1-plan counties	2/35	30/35	35/35	14/35
	# of members who move plans	N/A	0.4M (40%)	0.9M (89%)	0.2M (23%)
	% of providers with all contracted plans eliminated	N/A	7K (27%)	12K (44%)	3K (12%)
	Avg. % of deficiencies in BH networks	19%	17%	47%	17%
Regional– West NY	Avg. plan scale	0.1M members	0.7M members	0.7M members	0.2M members
	Avg. plan choice	3.5 plans	1 plan	0.05 plans	1.8 plans
	# of 0- and 1-plan counties	2/19	19/19	19/19	5/19
	# of members who move plans	N/A	0.4M (61%)	0.7M (90%)	0.3M (46%)
	% of providers with all contracted plans eliminated	N/A	6K (30%)	15K (73%)	2K (12%)
	Avg. % of deficiencies in BH networks	20%	17%	12%	17%

14.3 Glossary of Acronyms

- ABD: Aged, Blind, and Disabled
- ACA: Affordable Care Act
- ACM: Active Contract Management
- ACOs: Accountable Care Organizations
- ACT: Assertive Community Treatment
- ADL: Activities of Daily Living
- ALR: Administrative Loss Ratio
- APM: Alternative Payment Model
- BH: Behavioral Health
- BHET: Behavioral Health Expenditure Target
- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- CalAIM: California Advancing and Innovating Medi-Cal
- CCBHC: Certified Community Behavioral Health Clinic
- CCOs: Coordinated Care Organizations
- CDPAP: Consumer Directed Personal Assistance Program
- CHIP: Children's Health Insurance Program
- CLAS: Culturally and Linguistically Appropriate Services
- CMS: Centers for Medicare and Medicaid Services
- CoCM: Collaborative Care Model
- CORE: Community-Oriented Recovery and Empowerment
- COS: Comprehensive Operational Surveys
- CPEP: Comprehensive Psychiatric Emergency Program
- CPST: Community Psychiatric Supports and Treatment
- CTI: Critical Time Intervention
- DHCS: Department of Health Care Services
- DHPCO: Division of Health Plan Contracting and Oversight
- D-SNPs: Dual-eligible Special Needs Plans
- DSRIP: Delivery System Reform Incentive Payment
- ECP: Essential Community Providers
- EMR: Electronic Medical Record
- EQR: External Quality Review
- EQROs: External Quality Research Organization
- FAI: Financial Alignment Initiative
- FFS: Fee-for-Service
- FIDA-IDD: Fully Integrated Duals Advantage for Intellectual and Developmental Disabilities
- HARP: Health and Recovery Plans
- HCBS: Home- and Community-Based Services
- HEDIS: Healthcare Effectiveness Data and Information Set
- HIV SNPs: HIV Special Needs Plans
- HMO: Health Maintenance Organization
- HPSA: Health Professional Shortage Areas
- IDD: Intellectual and Developmentally Disabled
- IPRT: Intensive Psychiatric Rehabilitation Treatment
- LAN: Learning and Action
- LHCSAs: Licensed Home Care Services Agencies
- LTSS: Long-Term Services and Supports
- MAP: Medicaid Advantage Plus
- MCO: Managed Care Organization

- MHPAEA: Mental Health Parity and Addiction Equity Act
- MLR: Medical Loss Ratio
- MLTC: Managed Long-Term Care
- MLTCP: Managed Long-Term Care Partial Capitation
- MLTSS: Managed Long-Term Services and Supports
- MMC: Medicaid Managed Care
- NCQA: National Committee for Quality Assurance
- NIH: National Institutes of Health
- NPI: National Provider Identifier
- NYS: New York State
- OHIP: Office of Health Insurance Programs
- OMH: Office of Mental Health
- OQPS: Office of Quality and Patient Safety
- PACE: Program of All-Inclusive Care for the Elderly
- PCMH: Patient-Centered Medical Home
- PCP: Primary Care Physician
- PCSP: Person-Centered Service Planning
- PIP: Performance Improvement Plan
- PMPM: Per-Member Per-Month
- PNDS: Provider Network Data System
- POC: Plans of Correction
- POP: Performance Opportunity Project
- PROS: Personalized Recovery Oriented Services
- PSR: Psychosocial Rehabilitation
- QARR: Quality Assurance Reporting Requirements
- QIP: Quality Incentive Program
- REDCs: Regional Economic Development Councils
- RFI: Request for Information
- RFP: Request for Proposal
- RPC: Regional Planning Consortium
- SDOH: Social Determinants of Health
- SUD: Substance-Use Disorder
- UAS-NY CHAs: New York Uniform Assessment System of Community Health Assessments
- VBP: Value-Based Payment