The New York State Medicaid / Child Health Plus Program Quality Strategy

Prepared by:

The New York State Department of Health

Office of Health Services Quality and Analytics

Office of Health Insurance Programs

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The New York State Medicaid / Child Health Plus Program Quality Strategy:

The Blueprint for a Healthier State

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I. Introduction

The New York State Department of Health (NYSDOH), in collaboration with public and private partners, including the Centers for Medicare & Medicaid Services (CMS), is continuously seeking new strategies to improve the quality and experience of care while reducing health disparities.

Continued success depends on a quality strategy with clearly defined goals, objectives, metrics, targets, interventions, and mechanisms for transparency and feedback. The New York State Medicaid and Child Health Plus Program (CHPlus) Quality Strategy (hereafter referred to as the QS) aims to achieve measurable, meaningful improvement among twenty-one objectives in eight priority goal areas. Progress on the implementation and effectiveness of the QS will be monitored by a suite of measures, each of which correlates to one of the twenty-one objectives. The NYSDOH (Office of Health Insurance Programs and Office of Health Services Quality and Analytics) will review progress toward achieving goals at least annually.

The QS, a requirement of 42 CFR § 438.340 and 42 CFR § 457.1240(e), identifies the goals of the Medicaid and CHPlus program and the actions taken by NYSDOH to promote improvement. The QS has evolved as a result of programmatic changes, member health needs, clinical practice guidelines, federal and state laws, lessons learned, and best practices. The format of the QS has also evolved. The current version illustrates the relationships between different segments of care by using a matrix to display how various objectives work in conjunction to advance the QS's goals.

II. Medicaid and Child Health Plus Managed Care in New York State

Effective care management and care coordination are critical elements that support New York State (NYS) meeting the goals laid out in the QS. To support the vision of effective care coordination for all who need it, NYS intends to continue ensuring that the majority of Medicaid members are enrolled in Managed Care. New York's Children's Health Insurance Program (CHIP), referred to in NYS as Child Health Plus (CHPlus), is a fully managed care model. In NYS, Medicaid Managed Care and CHPlus are offered as distinct lines of business; however, organizations offering CHPlus plans must offer Medicaid Managed Care. Some managed care organizations in NYS are traditional insurance companies, while others are provider-based plans uniquely designed to meet the needs of special populations.

CHPlus serves the healthcare needs of uninsured children under the age of 19 who are not eligible for coverage under the public employees' state health benefits plan or Medicaid. Eligibility is based on a household size and income. There is also an option for households above the income for subsidized coverage to pay the full premium. CHPlus plans are required

to maintain a network of participating providers that offer comprehensive healthcare services which include but are not limited to well visits, inpatient and outpatient surgical care, inpatient and outpatient mental health and substance use, dental, vision, and emergency care.

NYS's Medicaid Managed Care (MMC) and CHPlus programs offers a variety of managed care organizations (MCOs) to coordinate the provision, quality, and payment of care for its enrolled members. Medicaid members not in need of specialized services are enrolled into Health Maintenance Organizations or Prepaid Health Services Plans (hereafter referred to as "mainstream MMC"). Members with specialized healthcare needs can opt to join available specialized managed care plans. Current, specialized plan types include:

HIV Special Needs Plans (SNPs)

The HIV Special Needs Plans (SNPs) meet the health, medical, and psychosocial needs of Medicaid-eligible individuals who are homeless or are living with HIV/AIDS. Children of eligible individuals living with HIV/AIDS are also eligible. HIV SNPs are required to have a network of experienced HIV service providers, HIV specialist Primary Care Providers (PCPs), and a comprehensive model of case management. HIV SNPs are also required to promote access to essential support services, such as treatment adherence, housing, and nutrition assistance, and to reach multi-cultural/non-English speaking communities.

Health and Recovery Plans (HARPs)

Health and Recovery Plans (HARPs) are overseen by the NYSDOH, the NYS Office of Mental Health (OMH), and the NYS Office of Addiction Services and Supports (OASAS). A HARP is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use). HARPs:

- manage the Medicaid services of their enrollees;
- manage an enhanced benefit package of behavioral health home and community-based services (BH HCBS) and Community Oriented Recovery and Empowerment (CORE) services; and
- provide enhanced care management for enrollees to help coordinate physical health, behavioral health, and non-Medicaid support needs.

Managed Long-Term Care (MLTC)

MLTC is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These long-term care services may include the medical, social, housekeeping, or rehabilitation services for a person's needs over months or years to improve or maintain function or health. MLTC MCOs ensure that individuals receive quality care that is delivered in the community in a cost-effective manner for those enrolled. As NYS continues to transform its long-term care system to one that ensures care management for all, enrollment in an

MLTC plan may be mandatory or voluntary, depending on individual circumstances. "MTLC Plans" refers to MLTC Partial Capitation Plans, Medicaid Advantage Plus (MAP) plans, and Programs of All-Inclusive Care for the Elderly (PACE) plans.

As of the end of 2023, there were 12 Mainstream Medicaid Managed Care plans, 12 HARPs, 3 HIV SNPs, 12 CHPlus plans, 19 MLTC Partial Capitation plans, 11 MAP plans, 9 PACE plans.

Regardless of plan type, NYS Medicaid and CHPlus MCOs ensure comprehensive healthcare services are available to all enrollees. NYS requires Medicaid and CHPlus MCOs to adopt practice guidelines consistent with current standards of care, and, where available, evidence-based practices, complying with recommendations of professional specialty groups or the guidelines of programs.

Examples of such programs and guidelines include:

- American Academy of Pediatrics,
- American Academy of Family Physicians,
- American Psychiatric Association,
- US Preventive Services Task Force,
- New York State Child/Teen Health Program (C/THP) standards for provision of care to individuals under age twenty-one years,
- American Medical Association's Guidelines for Adolescent and Preventive Services,
- US Department of Health and Human Services Center for Substance Abuse Treatment,
- New York State Office of Addiction Services and Supports (OASAS) clinical standards,
- American Society of Addiction Medicine (ASAM),
- US Substance Abuse and Mental Health Services Administration (SAMHSA),
- American College of Obstetricians and Gynecologists,
- American Diabetes Association,
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care developed by the Office of Minority Health of the US Department of Health and Human Services, and
- AIDS Institute clinical standards for adult, adolescent, and pediatric care.

NYS Medicaid MCOs also ensure that persons transitioning to managed care from fee-for-service (FFS) and persons in Medicaid or CHPlus transitioning between MCOs receive appropriate therapeutic, medical, and behavioral health services as part of the transition of care policy as set forth by 42 CFR 438.62 and 42 CFR 457.1216. Transition of care policies are included in the Model Member Handbooks.

NYS Medicaid and CHPlus transition of care policy requires that:

- In instances in which an enrollee newly transitions into a managed care health plan (either from FFS or another Medicaid or CHPlus managed care health plan or coverage type):
    - If an enrollee is in an ongoing course of treatment for a life-threatening disease or condition, or a degenerative and disabling disease or condition, the enrollee

may continue seeing his/her provider (even if they are out-of-network) for up to 60 days from the effective date of enrollment.
    - If an enrollee is pregnant in their 2nd or 3rd trimester, the enrollee may continue seeing their provider throughout their pregnancy and up to 12 weeks after delivery.
- In instances in which a provider leaves a Medicaid or CHPlus managed care health plan's network in good standing:
    - The enrollees may continue seeing that provider for up to 90 days.
    - If an enrollee is pregnant in their 2nd or 3rd trimester, the enrollee may continue seeing their provider throughout their pregnancy and up to 12 weeks after delivery.

CHPlus and Medicaid MCOs shall implement a transition of care policy that is consistent with the requirements of 42 CFR 438.62 and 42 CFR 457.1216.

NYSDOH monitors each CHPlus and Medicaid MCO's network of providers, professionals, and hospitals to ensure adequacy per contract standards. When establishing the network of providers, the MCO must consider anticipated enrollment, expected utilization of services by the population to be enrolled, characteristics of the population covered by the MCO, the number and types of providers necessary to furnish the services in the benefit package, the number of providers who are not accepting new patients, the geographic location of the providers and enrollees, language needs, the ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment, availability of triage lines and telemedicine capabilities, ability to support members' choice of provider, strategies to support community integration, and long term services and support needs. In addition, the MCO's network must contain all the provider types necessary to furnish the benefit package. For Medicaid, this includes providers of long-term support and services. The required types of network providers by line of business are available in the Provider Network Data System Dictionary.

The CHPlus and Medicaid Managed Care Model Contracts also addresses each piece of the availability of service standards, as required in 42 CFR 438.206. The Model Contracts also include requirements for managed care plans as they relate to their provider network, direct access to women's health specialists, medical and surgical second opinions, out-of-network care, credentialing, coverage of family planning services, and timely access to care. The Model Contracts require MCOs to deliver care in a culturally competent manner through access and cultural considerations. MCOs must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. Please see the table below for each topic and its respective section in the Model Contract(s).

Topic	Section(s) of Model Contract

	MMC/Family Health Plus/HIV SNP	Partial Capitation	Medicaid Advantage Plus (MAP)	PACE	FIDA-IDD	CHPlus
Transition of care policy	15.6	V.B, V.J	2.8, 5.4, Appendix S	III.H, V.H	2.5.3	20.7
Network adequacy	21	VII.D	21.2	V.D, V.H	2.7.1, 2.8	19.1
Availability of service standards	15.2	V.A, V.F	15	V.D, Appendix A-1	2.7.1.16, 2.9.2	20.2
Direct access to women's health specialists	10.12	Appendices B and G	Appendix K-1	Appendix A-1	2.7.1.29	2.3, 19.1.a.5
Medical and surgical second opinions	10.16	N/A	N/A	N/A	2.7.1.20	19.1.a.5, 19.2.b
Out-of-network care	21.2	VII.D.7	13.4.b	III.F.4.v.; Appendix B-C	2.8.1.4	19.2, 20.7
Credentialing	21.4	VII.C, VIII.B	21.4	III.F	2.7.1	19.4
Coverage of family planning services	10.10	Appendix G, non-covered services	10.6, Appendix C.2	N/A	2.9.3.1.15, Table A-2	20.15
Timely access to care	15.3, 15.4	V.A, V.F	15	Appendix B-C	2.7.1.16	20.1, 20.2, 20.4, 20.5
Culturally competent care	15.10	X.RR	15.2	IX.RR	2.1.14, 2.7.1.23	20.12
Accessibility	10.19, 24, Appendix J	IV, X.II	24, Appendix R.15	IX.GG, Appendix B	2.7.5.1. 2.8.1.5	11.10, 11.15, 19.1.a.5

If Medicaid or CHPlus MCOs engage in unacceptable practices, they can be subjected to the imposition of sanctions, including intermediate sanctions as authorized by NYS. Unacceptable practices for which Medicaid and CHPlus managed care health plans may be sanctioned include but are not limited to:

- Failing to provide medically necessary services that the health plan is required to provide under its contract with NYS.

- Imposing premiums or charges on enrollees that are in excess of the premiums or charges permitted under the Medicaid or CHPlus managed care program.
- Discriminating among enrollees on the basis of their health status or need for healthcare services.
- Misrepresenting or falsifying information that a health plan furnishes to an enrollee, potential enrollee, healthcare provider, NYS, or CMS.
- Failing to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR §§ 422.208 and 422.210.
- Distributing directly or through any agent or independent contractor, outreach/advertising materials that have not been approved by NYS or that contain false or materially misleading information.
- Violating any other applicable requirements of SSA §§ 1903(m) or 1932 and any implementing regulations.
- Failing to comply with the terms of the contract with NYS.
- Violating any relevant NYS or Federal law.

Intermediate sanctions applicable to Medicaid MCOs may include but are not limited to:

- Civil monetary penalties.
- Suspension of all new enrollment, including auto assignments, after the effective date of the sanction.
- Termination of the contract.
- Temporary management, pursuant to 42 CFR 438.702, 42 CFR 438.706 and 18 NYCRR 360-10.11(e).
- Denial of payment for new enrollees, pursuant to 42 CFR 438.730.

Similarly, intermediate sanctions applicable to CHPlus MCOs may include but are not limited to:

- Civil money penalties in the amounts specified in 42 CFR 438.704.
- Appointment of temporary management as provided in 42 CFR 438.706.
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.
- Suspension of all new enrollment after the date the Secretary of the Department of Health and Human Services or the State notifies the Contractor of a determination of a violation of any requirement under Title XXI of the Social Security Act.
- Suspension of payment for individuals enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

The State may impose intermediate sanctions on CHPlus plans, if the plan is found out of compliance with the terms and conditions of the CHPlus Model Contract in accordance with 42 CFR 457.1270 (cross referencing 42 CFR 438.700-438.704, 438.706(c) and (d), and 438.708-438.730) and PHL 2511(12-A).

All Medicaid and CHPlus managed care health plans are afforded due process pursuant to Federal and State Law and Regulations (42 CFR §438.710, 18 NYCRR Part 516, and Article 44 of the Public Health Law).

III. The Quality Strategy Purpose, Process, and Health Equity Focus

Purpose

The purpose of the QS is as follows:

- Establish a comprehensive quality improvement strategy for the NYS Medicaid/CHPlus program that is consistent with the National Quality Strategy;
- Assess the quality of care that NYS Medicaid/CHPlus members receive;
- Establish measurable goals of the NYS Medicaid/CHPlus program, set targets for improvement, and identify interventions to promote improvement;
- Align health promotion agendas across the NYS Department of Health to create a unified list of priorities;
- Create a framework for ongoing progress monitoring toward target rates statewide and within demographic strata, allowing for consideration of successful interventions and identification of disparities.

Process for Quality Strategy Development

NYSDOH partnered with United Hospital Fund (UHF), an independent, non-profit organization with extensive experience with health policy analysis, to approach building the QS from four angles:

1) Compile a list of broader NYSDOH health promotion and disease prevention strategies to ensure alignment.
2) Review the National QS as well as other State Strategies for inspiration.
3) Conduct feedback and learning sessions with subject matter experts from NYSDOH, NYS OMH, NYS Office of Children and Family Services (OCFS), NYS Office for People with Developmental Disabilities (OPWDD), and NYS OASAS. Participants were asked to make recommendations based on the previous QS as well as discuss current and upcoming programmatic goals and priorities.
4) Analyze current performance and trends on dozens of available quality measures to identify areas most in need of improvement.

In analyzing the information gleaned from these various approaches, NYSDOH first translated themes into goals and objectives for the QS and then tied metrics to each objective. Throughout this process, stakeholders from managed care health plans, policy groups, and a broader group of NYS agency staff were kept informed of progress and were asked to offer

feedback in order to build a QS that captures multiple perspectives, and to promote stakeholder investment in the QS. This collaborative process resulted in the goals and objectives matrix and measures list included in this QS. To promote alignment with other State priority areas, the first five goals highlighted in this QS closely mirror the five domains of New York's Prevention Agenda, the State's overarching health improvement plan: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

For each objective, NYSDOH compiled a list of relevant metrics collected by NYSDOH or otherwise publicly available. A lesson learned from prior years was to reduce the reliance on metrics that cannot be calculated by NYSDOH; published reporting on such measures is not consistent, and stratifications are not always possible. One to three metrics were carefully chosen for each objective through an extensive review process. In selecting measures, NYSDOH reviewed existing data to prioritize metrics that had room for improvement, were trending in an unfavorable direction, had known disparities, were performing below the national average, had a wide range of rates across managed care plans, were identified by subject matter experts as high value and high impact, and were closely aligned with the objective. NYSDOH sought to create a final measures list that was broad enough to reflect all populations and health service areas, while also being specific enough to measure the relevant objective. The measures were selected from the NYS Quality Assurance Reporting Requirements (QARR) Measurement Set, the Centers for Disease Prevention and Control's (CDC's) American Community Survey, 3M's Potentially Preventable Admissions (PPA), and other NYS specific measures, including member survey data. Measures that are from the QARR measurement set are only applicable to the Managed care population, however, in some cases NYSDOH can include fee-for-service populations in calculations for administrative measures using claims data. For other measures such as the 3M Potentially Preventable Admissions (PPA), the applicable population is identified in the text of the QS.

NYSDOH's Medical Care Advisory Committee (MCAC, as required by 438.340(c)(1)(i) and 431.12) membership spans two existing Committees: the Evidence Based Benefit Review Advisory Committee (EBBRAC) and the Medicaid Managed Care Advisory Review Panel (MMCARP). Though the EBBRAC was on hiatus during the development of this Quality Strategy, NYSDOH presented to, and solicited feedback from MMCARP, Health Plan Medical Directors, and the Managed Care Advocate Workgroup.

Additionally, per CMS requirements, the QS is placed on the NYSDOH's website for 30 days to provide accountability, transparency, and garner support and guidance from consumers, professionals, advocates, and policy makers, prior to the QS being finalized. NYSDOH staff respond to all comments and appropriate edits are made (see Section IX for more information on public comments).

Format & Focus on Health Equity

The NYSDOH has re-envisioned its QS to focus on 1) identifying objectives for the quality of the NYS Medicaid and CHPlus programs, which advance overarching goals, 2) tracking progress on at least one metric per objective, and 3) identifying, evaluating, and reducing extant health disparities within each metric.

A summary table of overarching goals and objectives is found in Section VI and a table of all selected metrics is found in Section VII. Additionally, Appendix 1 displays the source for each measure, baseline and target rates, how the target was calculated, as well as the applicable population. In order to further progress towards each goal, the NYSDOH implements several interventions that target improvement across the Medicaid and CHPlus populations. The NYSDOH has chosen to highlight within this report some, not all, of the interventions that are currently utilized to drive quality improvement towards the identified goals.

Section VIII of the QS describes each of the twenty-one objectives selected for this Strategy. For each objective, there are 4 sections: 1) a brief background that provides historical information or context for the selected objective, 2) a health equity section that explains known disparities related to the objective, 3) a summary of some of the interventions employed by NYSDOH to advance the objective, and 4) tables for the associated metrics chosen for the objective, including stratified rates per demographics where available. In previous years, the NYS Medicaid and CHPlus QS labeled certain objectives as being related to Cultural Competency (CC) or Social Determinants of Health (SDH); however, understanding that CC and SDH impact all aspects of care delivery, this QS aims to more fully explore CC and SDH impacts within each objective's health equity discussion. The Robert Wood Johnson Foundation defines health equity as, "…everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare."[i]

NYSDOH recognizes that it must increase the assessment and consideration of health equity in identifying gaps in care and in building interventions. To this end, there is an increased focus on using data to identify health disparities by age, race, ethnicity, sex assigned at birth, and disability status for all measures to the extent possible given data constraints. Measuring disparities is a critical step in addressing and reducing them. NYSDOH publishes quality data stratified by several demographic variables for public use: https://health.data.ny.gov/Health/Quality-Assurance-Reporting-Requirements-QARR-Heal/kt3x-cqb6 and https://health.data.ny.gov/Health/Quality-Assurance-Reporting-Requirements-QARR-Heal/x3xn-abgk/about_data For metrics included in the QS, demographic-stratified data from the above-linked dataset are included where available. These data highlight disparities in access to and utilization of healthcare.

Fee-for-Service (FFS) Inclusion

While many of the measures included in the QS are measured via QARR, and are therefore measuring performance in managed care plans, NYSDOH is committed to promoting a high-quality Medicaid program for all enrollees, regardless of enrolment type. The goals and objectives of the QS are applicable to all enrollees, and to the extent possible, NYSDOH will stratify measures by enrollment type (managed care vs FFS) to determine disparities throughout the upcoming years of measure monitoring.

IV. Measurement and Assessment of Medicaid and CHPlus Managed Care Organizations

NYSDOH has developed several systems to collect performance measurement data from Medicaid and CHPlus MCOs. MCOs are required to have information systems capable of collecting, analyzing, and submitting the required data and reports. Focused clinical studies and Performance Improvement Projects (PIPs) additionally capture quality of care information for specific populations and diseases.

Mainstream MMC and CHPlus plans, HARPs, HIV SNPs, and MLTC plans are required to conduct PIPs annually using a report template that reflects CMS requirements for a PIP. NYSDOH strongly encourages plans to participate in collaborative studies with a common theme. Examples of common-themed PIPs include blood lead testing, newborn hearing screening, and developmental screening for measurement year 2021.

To ensure the accuracy, integrity, reliability, and validity of the data submitted, the NYSDOH contracts with an External Quality Review Organization (EQRO). The EQRO validates PIPs and performance measures, reviews compliance with Medicaid and CHPlus program standards, administers quality of care surveys, audits data submissions, and provides technical assistance to MCOs in collecting and submitting requested information. The EQRO prepares an annual External Quality Review Technical Report, which are published on the NYSDOH website by plan type. This is further discussed in Section IX.

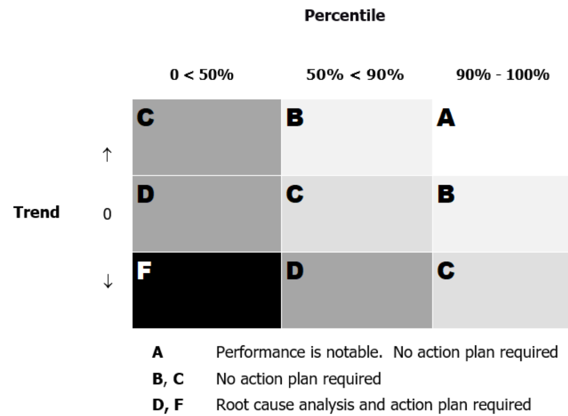
Quality Performance Matrix

To monitor health plan quality, a matrix was developed and implemented in 1998. The matrix approach provides a framework for benchmarking performance and helps plans prioritize quality improvement planning. The matrix gives a multi-dimensional view of plan performance by comparing rates for selected measures in two ways: 1) by percentile rank among other plans, and 2) trend over two years. The result, as shown in Figure 1, is a 3x3 table where measures are displayed in cells corresponding to a letter grade ranging from A (best performance) to F (worst performance).

For measures where there is poor performance, plans are instructed to conduct root-cause analyses and develop an action plan based on the barriers identified. The action plans are

reviewed and approved by NYSDOH Office of Health Services Quality and Analytics staff and are monitored throughout the year to ensure that they are being conducted and evaluated for effectiveness in improving performance.

Figure 1: The Quality Performance Matrix



Measures used to evaluate quality performance in NYS are largely based on The National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Original Source Data Submitter (which replaced the Encounter Intake System), Prevention Quality Indicator (PQI) measures developed by the Agency for Healthcare Research and Quality (AHRQ), the Uniform Assessment System for New York (UAS-NY), the National Core Indicators Survey (NCI), and consumer satisfaction surveys including the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. In addition to national measures obtained from these sources, NYS has expanded its evaluation of managed care organizations to include state-specific measures. The QARR quality measurement set, and other NYS-specific data sources used for assessment of the managed care delivery system in NYS are described below.

The Quality Assurance Reporting Requirements (QARR) Measurement Set

The collection of QARR data was implemented to monitor the quality of care delivered by managed care plans. QARR is a public reporting system largely based on HEDIS® measures of quality. QARR also includes NYS-specific measures and information collected using CAHPS® surveys. The NYSDOH sponsors a CAHPS® survey for both adult and children enrolled in Medicaid managed care and CHPlus. Adult and child surveys are conducted on alternating years. An MLTC-focused survey is also administered every two years.

QARR data are submitted annually by MCOs. QARR measures are grouped into the following areas:

- Adult Health

- Behavioral Health
- Child and Adolescent Health
- Provider Network
- Satisfaction with Care
- Women's Health

Measures address applicable healthcare needs of mainstream MMC, CHPlus, MLTC, HARP and HIV SNP populations. At the state level, QARR measures are used in many state initiatives including New York's Prevention Agenda, which is NYS's blueprint for state and local action to improve the health of New Yorkers and to reduce health disparities for racial, ethnic, disability, and socioeconomic groups. Several of these initiatives involve the use of quality measures at a health system or practice level. Aligning quality measures used in these programs, as well as value-based payment (VBP) programs, creates synergy in effort and reduces the cost and burden of collection. Additionally, with the Statewide Health Information Network for New York (SHIN-NY) and other initiatives, NYS is developing infrastructure and capabilities for leveraging health information technology for efficiencies in collection and transmission of data for quality measurement. The State also uses these quality measures to provide health plan quality ratings for all NYS Managed Care Plans. These are published annually through interactive dashboards and reports on NYS websites including: Managed Care Reports (https://www.health.ny.gov/health_care/managed_care/reports/) and Health Data New York.

Encounter Data Collected through the Original Source Data Submitter (OSDS) System

As of April 3, 2023, NYS Medicaid's Encounter Intake System (EIS) was sunset and subsequently all Medicaid and CHPlus MCOs are required to submit monthly encounter data to NYSDOH via the Original Source Data Submitter (OSDS). The OSDS collects data consistent with X12 and NCPDP national standards for a national uniform core data set. Encounter data provides a source of comparative information for MCOs and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, applying risk adjustment, and setting capitation rates. The Department ensures that reported encounter data is complete and accurate by utilizing an Encounter Data Quality (EDQ) performance evaluation program where MCOs are assessed based on three quality metrics: Timeliness, Completeness, and Accuracy.

Uniform Assessment System- New York

The Uniform Assessment System for New York (UAS-NY) is a New York State developed electronic assessment system that standardizes the identification and assessment of persons needing long-term services and supports (LTSS). The UAS-NY is based on assessment tools developed by interRAI, a collaborative network of researchers in over 30 countries committed to

improving healthcare for persons who are elderly, frail, or disabled. Their goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high-quality data. The interRAI organization and its assessment tools are used in many states as well as Canada and other countries.

In October 2013, NYSDOH began using the Community Health Assessment (CHA) in the UAS-NY system to identify Medicaid members' needs for home and community-based long term services and supports (LTSS) in New York. The CHA is conducted by a nurse assessor. The UAS-NY system establishes a single, unique functional record for all enrollees of NYS Medicaid's home and community-based long-term care services, further enabling comprehensive assessments. Additionally, the CHA is used to facilitate access to programs and services, eliminate duplicative assessment data, and improve consistency in the assessment process. The UAS-NY system also contains the interRAI Community Mental Health Assessment, which is used to determine HCBS eligibility for HARP members and HARP-eligible individuals enrolled in HIV SNPs.

The UAS-NY is also used for the Child Adolescent Needs and Strength-NY (CANS-NY). The CANS-NY serves as a guide in decision making for Health Homes Serving Children and HCBS Eligibility Determination for high risk needs children and youth. The CANS-NY is also a guide to service planning specifically for children and adolescents under the age of 21 with behavioral needs, medical needs, and developmental disabilities.

Data on Demographics

Good data is critically important to achieving health equity. NYSDOH obtains race, ethnicity, and primary language spoken from several sources including enrollment forms completed by recipients either in person at local departments of social services (LDSSs) or online through the NY State of Health, and health assessment forms mailed to new enrollees by both LDSSs and MCOs. Completed enrollment forms are forwarded to the MCO. MCOs are required to submit member-level specific Quality Assurance Reporting Requirements (QARR) data that, combined with the collection of CAHPS® (satisfaction) survey data, enable the NYSDOH to calculate QARR rates by demographic characteristics including race/ethnicity, age, and Medicaid aid category. These demographic-level reports allow further evaluation of the quality of care received by populations with significant and or discrepant healthcare needs, including Safety Net and Supplemental Security Income (SSI) populations.

V. Measurement and Assessment of the Quality Strategy

As previously noted, NYSDOH has identified twenty-one objectives that tie to eight overarching goals. To measure progress on each objective, NYS has identified metrics that currently exist within the quality improvement structure of the NYS Medicaid and CHPlus programs for inclusion within the QS. These metrics measure improvement in access to care, quality of care,

reduction in health disparities, and the overall health and wellness of NYS Medicaid and CHPlus enrollees.

To achieve health equity, health disparities based on sex, race, ethnicity, and disability status must be reduced. NYS defines disability as the inability of an individual to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve months. Historically, NYS Medicaid has relied on Supplemental Security Income (SSI) eligibility as a proxy for disability. However, recognizing that CHPlus members are not eligible for SSI, NYSDOH has created a definition for disability within Medicaid and CHPlus enrollment and claims data, referred to in QS data tables as the "Administrative Definition." Those meeting any of the following criteria are included in the disability stratification used for the QS where "Administrative Definition" is noted: Members eligible for SSI (Medicaid only); members with diagnoses of blindness, deafness, physical disability, serious mental illness or serious emotional disturbance, or intellectual or developmental disabilities; members with durable medical equipment (DME) for mobility impairments or those who use non-emergency ambulance transportation to Medicaid-covered services; and members with intensive services for mental health needs. This definition is evolving as stakeholder input is collected and NYSDOH intends to incorporate self-reported disability status into the definition. For some of the baseline data presented in this QS, the SSI-based definition of disability is used because the newer definition was not available at the time of measurement. Each metric table includes a notation describing which disability definition was employed. For ongoing internal measure monitoring, NYSDOH intends to employ the enrollment and claims-based definition.

To measure health disparities, metrics included in the QS are stratified by enrollee demographics wherever possible, including plan type, age, sex, race/ethnicity, and disability status. For some measures, stratification was not possible at baseline measurement.

Demographic characteristics were extracted from Medicaid member information collected during Medicaid enrollment. The following are the definitions of the demographic characteristics:

- **Race/Ethnicity** is defined as mutually exclusive categories of Asian/Pacific Islander, Black, Hispanic, White, Unknown or Other. It is possible for a member to denote that they belong to more than one race. Therefore, for purposes of this data, an algorithm was developed to ensure each member was assigned to just one race/ethnicity category. A member who self-identifies as Hispanic is defined as Hispanic, regardless of any other races noted. White race includes non-Hispanic whites without any other race noted. Similarly, Blacks and Asians include only non-Hispanic single race categorizations. Members of multiple races and Native Americans race/ethnicity are assigned to the category "Other" Race/Ethnicity.
- **Age** is defined as the member's age in years as of the end of the measurement year. Different age groups are created based on the eligible population for each measure.
- **Sex** indicates the member's sex assigned at birth, defined as Male or Female.

- **Disability** is identified using member enrollment, diagnosis, DME, and service utilization, as described above.

Stratified measures will be updated annually to evaluate the effectiveness of NYS's Medicaid and CHPlus programs in addressing and mitigating observed disparities.

Most metrics included in the QS have a baseline rate using 2021 as the benchmark year (unless otherwise specified within the QS) and a 3-year performance target rate. Unless otherwise noted, to establish performance targets, NYS uses a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and the 90th percentile of all Medicaid managed care plan performance. For example, if the baseline rate was 72 percent, and the 90th percentile of plan performance was 86%, NYS would be expected to improve the rate by 1.4 percentage points to 73.4 percent. This is calculated as 1.4%= 10% x (86% – 72%). When this calculation results in improvement of less than one percentage point, the gap closure target will instead be set at the performance rate in the prior calendar year plus one percentage point. Each measure that shows improvement equal to or greater than the performance target is considered achieved.

VI. Quality Strategy Goals and Objectives Table

		Goals							
	Objective List	1. Prevent and manage chronic diseases	2. Promote Healthy and Safe Environments, Supporting Members in their Communities	3. Promote Healthy Women, Infants, and Children	4. Promote Wellbeing & Prevent & Manage Mental Health and Substance Use Disorders	5. Prevent and Manage Communicable Diseases	6. Improve Systems and Infrastructure	7. Increase Access to Care	8. Promote High Quality Outpatient Care
1	Support and advance an equitable Medicaid and CHPlus program	x	x	x	x	x	x	x	
2	Promote a system that facilitates consistent access to care	x	x	x	x		x	x	
3	Ensure coordinated care and promote integrated care	x	x	x	x				
4	Support members in their communities		x						
5	Promote Community Based Organization partnerships	x	x	x	x	x	x	x	
6	Improve the health and safety of members' environments	x	x	x	x	x	x		
7	Promote a sustainable provider workforce and capacity						x	x	x
8	Ensure and incentivize high quality care						x		x
9	Improve access to and quality of behavioral healthcare	x		x	x	x		x	x
10	Improve access to and quality of dental care	x		x				x	x
11	Improve access to and quality of maternal healthcare	x		x	x	x	x	x	x
12	Improve access to and quality of Home and Community Based Services	x	x	x		x	x	x	x
13	Improve access to and quality of patient-centered primary care	x	x	x	x			x	x
14	Improve access to and quality of care for infants and children	x	x	x	x	x	x	x	x
15	Improve access to and quality of chronic disease management	x	x	x				x	x
16	Increase utilization of preventive healthcare services	x		x					x
17	Prevent chronic disease	x	x	x		x			
18	Promote data-driven Medicaid oversight and health plan accountability	x					x		
19	Promote member safety	x	x	x		x		x	
20	Reduce unnecessary ER visits and hospitalizations	x	x		x			x	x
21	Ensure members are able to receive care in the least restrictive setting possible		x						x

Throughout this QS, the goals most impacted by the chosen objectives are highlighted using this visual aid.

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

For example, objective 3: “Ensure coordinated care and promote integrated care” is most related to goals 1-4 listed above. Those goals are highlighted in the graphic that accompanies objective 3 in Section VIII.

VII. Quality Strategy Measures Table

	Objective List	Measures
1	Support and advance an equitable Medicaid and CHPlus program	1.1 Reduce the number of uninsured
2	Promote a system that facilitates consistent access to care	2.1 Getting Care Quickly (CAHPS)
3	Ensure coordinated care and promote integrated care	3.1 Proportion of total population in MAP, PACE and Partial in a MAP or PACE
4	Support members in their communities	4.1 Quality of Home Health Aide/Personal Care Aide
5	Promote CBO partnerships	5.1 Social Need Screening and Intervention
6	Improve the health and safety of members' environments	6.1 No Falls Injury
7	Promote a sustainable provider workforce and capacity	7.1 Medicaid Enrolled Dentists
8	Ensure and incentivize high quality care	8.1 Proportion of members in a PCMH
9	Improve access to and quality of behavioral healthcare	9.1 Follow-Up After Emergency Department Visit for Substance Use - 7 & 30 day
		9.2 Follow-Up After Emergency Department Visit for Mental Illness - 7 & 30 day
10	Improve access to and quality of dental care	10.1 Topical Fluoride for Children
		10.2 Annual Dental Visit (PIP Measure--Adults)
11	Improve access to and quality of maternal healthcare	11.1 Postpartum Care
12	Improve access to and quality of Home and Community Based Services	12.1 Members in 1915c programs with Physical Exam
13	Improve access to and quality of patient-centered primary care	13.1 Proportion of members who utilize primary care
14	Improve access to and quality of care for infants and children	14.1 Well-Child Visits in the First 30 Months of Life
		14.2 Child and Adolescent Well-Care Visits
		14.3 Follow-Up Care for Children Prescribed ADHD Medication
15	Improve access to and quality of chronic disease management	15.1 Viral Load Suppression
		15.2 Hemoglobin A1c Control for Patients with Diabetes
		15.3 Asthma Medication Ratio – Both Adult and Child (5-64)
16	Increase utilization of preventive healthcare services	16.1 Colorectal Cancer Screening
		16.2 Childhood Immunization Status (Combo 10)
17	Prevent chronic disease	17.1 Hep C Elimination Measure -- Universal screening for pregnant people
18	Promote data-driven Medicaid oversight and health plan accountability	18.1 Completeness of Race/Ethnicity Data
19	Promote member safety	19.1 Pharmacotherapy for Opioid Use Disorder
20	Reduce unnecessary ER visits and hospitalizations	20.1 Follow-Up After Hospitalization for Mental Illness - 7 & 30 day
21	Ensure members are able to receive care in the least restrictive setting possible	21.1 Potentially Preventable Admissions

VIII. Goals, Objectives, and Measures Descriptions

Objective 1: Support and advance an equitable Medicaid and CHPlus program

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

Background: New York State's population is approximately 19.7 million[ii], with about 40% of the State population enrolled in Medicaid.[iii] Advancing health equity starts by promoting health insurance coverage for all, especially those living under the Federal Poverty Level (FPL). Adult New Yorkers qualify for Medicaid based on income if they earn up to 138% of the FPL, and children qualify for Medicaid based on 154% FPL (eligibility for CHPlus without a premium is 222% FPL; eligibility for CHPlus with a monthly subsidized premium is 400% FPL and a full pay option exists above 400% FPL)[iv]. NYSDOH's goal is to enroll all uninsured New Yorkers meeting Medicaid and CHPlus eligibility guidelines in order to promote preventive health and access to needed care. In 2021, the US Census Bureau estimated about 5.2% of New Yorkers were uninsured.[v]

Health Equity: Health insurance coverage impacts access to care[vi], and disparities in health coverage exist among racial and ethnic groups, with non-White people having higher uninsured rates.[vii] NYSDOH is committed to better understanding where disparities exist and working to eliminate them. NYSDOH's Office of Minority Health was redefined as the Office of Health Equity and Human Rights (OHEHR) in 2022. OHEHR was formed to improve health equity and reduce disparities across racial, ethnic, and socioeconomic groups while leveraging data to inform policies and improve health outcomes and takes a collaborative approach to setting priorities and building health promotion campaigns with stakeholder input[viii]. Specific units within OHEHR focus on inclusion, violence prevention, and health disparities.

Intervention(s): NYSDOH's NY State of Health Marketplace (https://nystateofhealth.ny.gov/) was developed to make health insurance enrollment and comparisons as simple as possible, and to help New Yorkers understand when they qualify for Medicaid or CHPlus. Through CHPlus, thousands of children who do not qualify for Medicaid have access to free or affordable health insurance. Though some re-enrollment flexibilities afforded during the COVID-19 Public health Emergency (PHE) are expected to impact the uninsured rate in NYS post-PHE, NY State of Health launched a significant marketing strategy, which increased marketing to promote use of the enrollment website, created a text and email alert system for important health insurance updates and renewal reminders, held numerous stakeholder sessions to explain the PHE unwind and how New Yorkers can maintain health insurance, and did direct outreach via Navigators and Facilitated Enrollers. NYS uses the "ex parte" process to automate Medicaid

and CHPlus renewals using extant data, and estimates about 40% of households on NY State of Health Marketplace are renewed via ex parte.

<table>
<tr><td colspan="4">Metric 1.1: Reduce the number of uninsured</td></tr>
<tr><td colspan="4">Measure Description: Rate of uninsured people under 100% FPL in New York State in measurement year (for statewide rate and adult stratification); Rate of uninsured children under age 19 under 400% FPL in New York State in measurement year.

Source: American Community Survey</td></tr>
<tr><td colspan="2"></td><td>Baseline Rate (2021)</td><td>Target Rate</td></tr>
<tr><td colspan="2">Statewide[ix] (Age 0-64)</td><td>9%</td><td>8%</td></tr>
<tr><td>Age</td><td>Children Under 19</td><td>3%</td><td></td></tr>
<tr><td></td><td>Adults 19-64[x]</td><td>13%</td><td></td></tr>
</table>

Objective 2: Promote a system that facilitates consistent access to care

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

Background: The NYSDOH aims to steward a health system where members can readily access services. Individuals without consistent access to care may not engage with preventative and ongoing care, ultimately reducing the likelihood of achieving their best health. Inconsistent access can be the result of gaps in insurance coverage, insufficient provider density, or prolonged wait times to get an appointment.

Health Equity: Marginalized and underserved populations may face significant barriers to receiving consistent care. For example, transgender adults are more likely than cisgender adults to have trouble getting an appointment quickly and accessing healthcare at a convenient location[xi]. Rural communities are more likely to experience provider shortages and travel further distances for needed care[xii].

Intervention(s): With the end of continuous enrollment in Medicaid and CHPlus post-PHE, the NY State of Health Marketplace heightened its communication about Medicaid and CHPlus renewals and free enrollment assistance to avoid gaps in coverage. Assistance is available in many languages other than English and during non-traditional hours like evenings and weekends.

The Medicaid Managed Care and CHPlus Model Contracts include a variety of access requirements. Managed Care Plans must follow appointment availability standards to ensure members connect with providers quickly, such as seeing a provider within 72 hours for a non-urgent sick visit. They are also held to travel time standards to ensure the provider network is geographically accessible to members. Provider network reports are used to monitor compliance with access standards. NYSDOH conducts a survey each year, alternating its focus between adult and child members, to monitor access to care.

The New York State Patient Centered Medical Home Program offers financial incentives to primary care providers who demonstrate patient-centered, high-quality practices. Patient Access is a core competency of the model. Criteria include evaluating access to appointments, operating beyond regular business hours, and using secure electronic systems to facilitate additional means of patient-provider communication. Additionally, to improve rates of completion of the health screening forms, plans occasionally uses nominal incentives as permitted by the Medicaid Managed Care and Child Health Plus contracts and with the NYSDOH's prior approval.

The Medicaid Transportation program ensures Medicaid members can get to and from medical appointments. It arranges non-emergency transportation, such as pre-scheduled trips to primary care and dental appointments, at no cost to the member. This essential benefit removes a barrier to care and accommodates each person's medical mobility needs.

<table>
<tr><td colspan="6">Metric 2.1: Getting Care Quickly</td></tr>
<tr><td colspan="6">Measure Description: Measures members' perception of how quickly they received care when it was sought in the last 6 months (Medicaid). Members were asked how often they were able to: Receive needed care right away. Get an appointment for healthcare at a doctor's office or clinic as soon as they thought care was needed. Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Usually" or "Always."

Source: CAHPS</td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="2">Baseline Rate</td><td colspan="2">Target Rate</td></tr>
<tr><td>Child (2020)</td><td>Adult (2021)</td><td>Child</td><td>Adult</td></tr>
<tr><td colspan="2">Adult Survey: Mainstream Medicaid Managed Care and HIV SNP (age 18+), HARP (age 21+)

Child Survey: Mainstream Medicaid Managed Care and HIV SNP (age 0-17), CHPlus members</td><td>88%</td><td>79%</td><td>91%</td><td>85%</td></tr>
<tr><td>Plan Type</td><td>Medicaid (Medicaid + CHPlus for Child Survey)</td><td>88%</td><td>79%</td><td></td><td></td></tr>
<tr><td></td><td>HARP</td><td></td><td>80%</td><td></td><td></td></tr>
</table>

	HIV SNP		81%		

Objective 3: Ensure coordinated care and promote integrated care

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

Background: NYSDOH promotes coordinated care within Medicaid by using a robust managed care system. In 2023, there are approximately 8 million New Yorkers enrolled in NYS Medicaid, of which, over 75% are enrolled in a managed care plan. For members in need of managed long term care (MLTC), there are MLTC Partial Capitation plans, Programs of All-Inclusive Care for the Elderly (PACE) plans, and Medicaid Advantage Plus (MAP) plans. PACE and MAP plans coordinate and manage all benefits for enrolled members, while MLTC Partial Capitation plans manage a portion of benefits. In 2022, NYSDOH published a Dual Eligible Integrated Roadmap, outlining efforts to encourage enrollment in MAP and expanding PACE enrollment opportunities[xiii].

Health Equity: People dually eligible for Medicaid and Medicare are more complex populations with higher rates of chronic illness and are more likely to report a "poor" health status[xiv]. Because of their dual enrollment, they risk experiencing fragmented care. By integrating and coordinating care for these members, more efficient and holistic care can lead to better health outcomes[xv].

Intervention(s): NYSDOH's Integrated Care Roadmap aims to 1) create more opportunities to build alignment between Medicare and Medicaid through integrated MCO offerings; 2) streamline MCO offerings and promote informed member choice; 3) enable fewer member transitions and build stronger continuity of care; and 4) simplify administrative infrastructure for providers and MCOs. To achieve these goals, there are several initiatives underway. When a member becomes Medicare-eligible, there is default enrollment in MAP where appropriate. Additionally, increased marketing of integrated plans as well as alternative processes for PACE enrollment are intended to increase MAP and PACE enrollment. NYSDOH also aims to promote integration of physical and behavioral healthcare, which is described in more detail in objective 9.

Metric 3.1: Proportion of total population in MAP, PACE and Partial in a MAP or PACE
Measure Description: Proportion of total population in MAP, PACE and Partial in a MAP or PACE **Source:** NYS Medicaid Enrollment Data[xvi]

		Baseline Rate (2022)	Target Rate
Statewide (MAP, PACE, and Partial Capitation MLTC Plan Members, Age 18+)		14%	15%
Race	Asian/Pacific Islander	7%	
	Black	17%	
	Hispanic	24%	
	White	6%	
	Unknown or Other	12%	
Sex	Male	12%	
	Female	15%	
Disability	Yes (Administrative Definition)	17%	
	No (Administrative Definition)	8%	

Objective 4: Support members in their communities

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

Background: NYSDOH strives to support members with high-quality care in the least restrictive setting possible. Opportunities to receive services outside an office or institutional setting improves access and puts the patient at the center of care. NYSDOH promotes this through various Home and Community Based Services (HCBS) programs as well as other initiatives to connect members to care in their communities. 97% of Medicaid Managed Long-Term Care members reside in the community[xvii].

Health Equity: Community-based care reduces barriers related to travel, allows people to remain in familiar, comfortable environments, and enables caregivers to observe social and environmental factors influencing the patient's wellness. A study found that patients treated through a hospital-at-home program were less likely to be readmitted to the hospital compared to the inpatient control group, with an even greater difference for those enrolled in Medicaid. This suggests that economically disadvantaged patients may receive greater benefit when providers can observe and address social determinants of health.[xviii]

Intervention(s): NYSDOH brings care to members in their communities through many programs. The Consumer Directed Personal Assistance Program (CDPAP) aids with activities of daily living and skilled nursing services for individuals who need home care. CDPAP empowers members with flexibility and autonomy in choosing their caregivers and the type of assistance they wish to receive.

The Money Follows the Person (MFP) Demonstration funds a network of 24 Open Doors Transition Centers which serve as a resource for individuals living in institutional care who would like to explore transitioning back into the community. The centers help individuals identify needed supports, coordinate medical services, and offer peer support to assist with community integration. MFP promotes autonomy and quality of life by connecting people to community-based care.

The NYS Medicaid and CHPlus Programs cover a range of telehealth services which facilitate care at home or locations convenient for the patient and provider. Many telehealth benefits initially covered under the COVID-19 PHE became permanent covered services for Medicaid and Child Health Plus members. Under NYS Law Chapter 45 Article 29-G §2999-DD, New York implemented payment parity for services delivered via telehealth to support providers offering this important benefit.

NYS currently covers community health worker (CHW) services for pregnant and postpartum Medicaid members. Starting in 2024, coverage will expand to include children under age 21 and special adult populations. CHWs provide health advocacy, education, and navigation to support health-related social needs.

Metric 4.1: Quality of Home Health Aide/Personal Care Aide			
Measure Description: Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as good or excellent **Source:** Satisfaction Survey (MLTC)			
		Baseline Rate (2021)	Target Rate
Statewide (Sample of MLTC, PACE, and MAP members age 18+)		91%	95%
Plan Type	PACE	85%	
	Partial Cap (MLTC)	92%	
	MAP	93%	

Objective 5: Promote Community Based Organization partnerships

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

Background: Community Based Organizations (CBOs) are uniquely able to improve health and social needs by rendering services in the communities where Medicaid and CHPlus members live. CBOs have insights into local needs, support structures, cultures, and history that are invaluable in creating health promotion programs that truly address the community's needs and promote participation.

Health Equity: Recognizing that structural determinants and socioeconomic factors play a role in a person's health, addressing social care needs is an important factor in improving overall health. During the COVID-19 PHE, there was a disproportionate health impact on low wage workers and people of color[xix]. Social and economic factors like type of employment and caregiver status can impact likelihood of illness or infection, while also presenting barriers to easily accessing needed care. Addressing health related social needs helps promote equitable healthcare by removing structural and socioeconomic barriers.

Intervention(s): NYSDOH promotes partnerships with CBOs by requiring contracts with CBOs in certain Value Based Payment (VBP) arrangements. In 2022, NYSDOH drafted an 1115 Waiver Amendment "New York Health Equity Reform (NYHER)" to advance health equity, reduce health disparities, and support the delivery of social care[xx], which was approved by CMS in January 2024[xxi]. The waiver aims to build partnerships with CBOs throughout the State in order to address social care needs. NYSDOH intends to emphasize the need for social needs screening for all Medicaid members, which will lead to referrals to needed services.

Metric 5.1: Social Need Screening and Intervention		
Measure Description: The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. **Source:** QARR		
	Baseline Rate	Target Rate
Statewide (Mainstream Medicaid managed care, HARP, and HIV SNP members)	Not Available (to be reported in 2024)	20%

Objective 6: Improve the health and safety of members' environments

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

Background: Health is impacted by environmental factors such as air and water quality, exposure to toxic substances, and the accessibility of a space. People who live in unhealthy environments are at greater risk of illness and injury. Falls are the leading cause of unintentional injury deaths for those 45 years and older in New York. NYSDOH recognizes the importance of healthy natural and built environments. "Promote a Healthy and Safe Environment" is a priority area of the Prevention Agenda and many programs focus on the ensuring the spaces where people live, work, learn, and play support their wellbeing.

Health Equity: Different geographic areas and populations bear different environmental conditions. Urban areas experience more pollution and subsequently worse air quality than rural areas. Communities with lower incomes and neighborhoods of color experience greater risk of exposure to water quality health violations and contaminants.[xxii] Accessible housing is scarce, with less than five percent of housing being accessible for those with moderate mobility difficulties.[xxiii]

Intervention(s): Social and environmental supports, including home and environmental modifications are available to members in MLTC plans as well as some waiver participants. Additionally, the Access to Home Medicaid program provides home modifications such as ramps, lifts, and handrails, to ensure individuals living with a disability can safely remain in their homes. These adaptations improve quality of life and prevent individuals from entering institutional care while lowering healthcare costs.

Many managed care plans offer social care need interventions in collaboration with community-based organizations that focus on neighborhood and environment. For example, HealthFirst partners with A.I.R. NYC to provide home visits, environmental assessments, and health education through community health workers for pediatric asthma patients. Identifying asthma triggers and finding solutions avoids unnecessary school absences and emergency department visits.

Similarly, the NYSDOH is collaborating with the New York State Energy Research Development Authority (NYSERDA) on the Healthy Home Value-Based Payment Pilot. This pilot delivers interventions to 500 households in targeted regions of the State to address energy efficiency, weatherization, environmental trigger reduction, and home injury prevention measures. It also includes home visits from RNs and community health workers to support the families.[xxiv]

The NYSDOH Center for Environmental Health is dedicated to ensuring the safety of New Yorkers' environments. Their work includes include indoor air quality assessments for schools and other public buildings, maintaining registries of exposure risks, regulating water supplies, and developing injury protection programs.

Metric 6.1: No Falls Injury
Measure Description: Percentage of members who did not experience falls that resulted in major or minor injury in the last 90 days. **Source:** Community Health Assessment

		Baseline Rate (2022)	Target Rate
MAP, PACE, and Partial MLTC plans; members aged 18 and older		90%	91%
Race	Asian/Pacific Islander	90%	
	Black	93%	
	Hispanic	91%	
	White	89%	
Sex	Male	90%	
	Female	90%	

Objective 7: Promote a sustainable provider workforce and capacity

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

Background: Ensuring an adequate number of providers with the capacity to serve all Medicaid and CHPlus members is a critical component of the State's healthcare infrastructure. According to healthcare employers, a shortage of workers is cited as a main reason for recruitment challenges within healthcare.[xxv] New York State has Health Professional Shortage Areas (HPSAs) (as designated by Health Resources and Services Administration (HRSA)) in primary care, dental care, and mental health.[xxvi] Within NYS Medicaid, increasing the number of participating dental providers and overall access to dental care is a priority area.

Health Equity: Illustrated by the existing HPSAs in NYS, the distribution of providers is incongruous with population distribution, creating unequal access to healthcare in more rural regions of the State. Participation with Medicaid as well as service rates among participating providers are important determinants of health for low-income New Yorkers[xxvii], and participation rates with Medicaid tend to trail behind Medicare and commercial insurers.[xxviii]

Intervention(s): NYSDOH's NYHER Waiver Amendment includes a focus on workforce via training program development, loan forgiveness, and workforce investments. Additionally, in 2022, NYSDOH created a Workforce Innovation Center to develop and evaluate programs intended to strengthen the State's healthcare workforce, as well as allocated $1.2 billion in funding for frontline healthcare worker bonuses[xxix]. Within the Medicaid program, significant

increases to physician fee schedules were implemented in 2022 and 2023 in an effort to expand provider capacity to participate with Medicaid.

NYSDOH collects MCO provider network data via the Provider Network Data System, and systematically reviews Medicaid and CHPlus networks against adequacy standards in each county. NYSDOH communicates adequacy findings with each health plan and requires that they resolve any network gaps. Data are also used to populate the NYS Provider & Health Plan Look-Up, a tool that allows consumers to search for available providers across plans and networks. NYSDOH's EQRO completes access and availability studies using a "secret shopper" method to track provider availability and wait times to appointments.

Increasing dental provider participation to improve dental access is a priority within the Medicaid and CHPlus programs. The first step in building interventions to increase participation is a dental provider survey, which will seek to gain insights about barriers and perspectives about Medicaid participation. This survey will be fielded in late 2023.

Metric 7.1: Medicaid Enrolled Dentists		
Measure Description: Proportion of licensed dentists in NYS (SED licensure data) who have billed NYS Medicaid during the calendar year (includes dentists listed as servicing provider on a claim). **Source:** NYS Licensure Data; Medicaid Claims Data		
	Baseline Rate (2022)	Target Rate
Statewide	42%	46%

Objective 8: Ensure and incentivize high quality care

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

Background: The healthcare landscape is increasingly moving away from fee-for-service, quantity-driven models toward value-based, outcome-driven payment models. NYSDOH's Delivery System Reform Incentive Payment (DSRIP) program concluded in 2020, but NYSDOH has reaffirmed its commitment to value-based payment and continues to expect Managed Care Organizations to adhere to the DSRIP goals. This approach is increasingly woven into NYSDOH programs beyond managed care to emphasize and reward quality through many pathways.

Health Equity: Healthcare must be equitable for it to be considered high quality. Value-based payment models are an opportunity to emphasize and make stakeholders accountable for addressing disparities, implicit bias, and barriers in their work.

Intervention(s): The NYHER Waiver (described in objective 5) focuses on health disparities and systemic healthcare delivery issues. The goal is to move forward linked initiatives that change how Medicaid integrates and pays for social, physical, and behavioral healthcare. A single statewide independent Health Equity Regional Organization (HERO) entity is intended to bring a diverse and comprehensive range of stakeholders together to collaboratively support data aggregation, regional needs, assessment and planning, VBP Design and development, and program evaluation. [xxx]

NYSDOH continues to incentivize high quality care through other existing program as well. The Managed Care Quality Incentive Program is an opportunity for plans to receive premium bonuses based on their performance in quality and patient satisfaction measures. It combines quality of care, consumer satisfaction, and compliance measures to determine the incentive award. The Quality Assurance Reporting Requirements (QARR) data used for this program is publicly available at health.data.ny.gov. Additionally, the quality measures feed into the 5-Star Health Plan Quality Ratings Dashboard on the NYS Connector webpage which helps New Yorkers make informed decisions when choosing health plans.[xxxi]

The Patient Centered Medical Home program (described in Objective 2) offers financial incentives to primary care providers who demonstrate patient-centered, high-quality practices. Studies support the model's success in delivering high-quality care while reducing costs, demonstrating lower average annual spend per member, fewer emergency department visits, and improved patient experience.[xxxii] PCMH incorporates equity into its model through criteria such as social determinant of health interventions and culturally and linguistically appropriate services. NYSDOH continues to promote the PCMH program and intends to align a portion of the incentive payment to provider performance in alignment with CMS' Making Care Primary program in the future.

Metric 8.1: Percentage of members in a Patient Centered Medical Home (PCMH)			
Measure Description: Percentage of all Medicaid and CHPlus members assigned to a PCMH recognized PCP. Medicaid rate based on 2021 data; CHPlus based on 2022 data **Source:** NCQA PCMH Data; Medicaid Panel/Roster Data			
		Baseline Rate (2022)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP, HIV SNP) (Statewide calculation does not include CHPlus though it is included in the below stratification)		66%	67.5%
Plan Type	Medicaid	66%	
	HARP	69%	
	HIV SNP	85%	
	CHPlus	71%	

Objective 9: Improve access to and quality of behavioral healthcare

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

Background: Behavioral healthcare services, including mental health treatment and addiction supports and services, are covered services in NYS' Managed Care Programs and because of the critical nature of these services, a specialized plan type (Health and Recovery Plans, or HARPs) was created to serve the Medicaid populations most in need of behavioral health services. HARPs offer increased coverage of home and community-based services, including peer support and crisis intervention, as well as increased support for transitions of care and independent living. One in five people have a mental health condition but there are not enough behavioral health professionals to meet New Yorkers' needs within the State[xxxiii] [xxxiv]. Integrating behavioral health into primary care settings can help alleviate access issues and take a more preventive and holistic approach to treating patients' physical and mental health.

Health Equity: People from racial and ethnic minority groups are less likely to receive mental healthcare and may be more at risk for under- and mis-diagnoses of mental illness.[xxxv] Further, recent research has shown that opioid overdose deaths disproportionately impact Black Americans and people in urban communities and that the COVID-19 pandemic exacerbated these disparities.[xxxvi] Nationally, Medicaid is the largest payer for mental health services[xxxvii] and the rate of emergency department visits for behavioral health services increased in recent years likely as a reflection of the opioid epidemic.[xxxviii]

Intervention(s): NYSDOH has taken steps to remove barriers to behavioral health services, including promoting the use of telehealth where appropriate, covering non-emergency medical transportation to mental health and substance use services, and allowing for treatment in place by ambulance providers as appropriate through the Emergency Triage, Treat, and Transport (ET3) model until the federal ET3 program ends on December 31, 2023. Additionally, Medicaid and CHPlus MCOs must report annually on a suite of behavioral health metrics via QARR.

NYSDOH partners with sister agencies, OMH and OASAS, to create policies that promote the health and safety of Medicaid members with behavioral healthcare needs. The Collaborative Care Medicaid Program is an OMH-run program that incentivizes participating primary care providers who have integrated mental health services into their practices. NYSDOH, OMH, and OASAS partner in overseeing the Integrated Outpatient Services (IOS) license for clinics with integrated physical and behavioral health services, which expands availability of services and improves care coordination.

Metric 9.1: Follow-Up After Emergency Department Visit for Substance Use - 7 & 30 day

Measure Description: Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. **Source:** QARR					
		Baseline Rate (2022)		Target Rate	
		7-Day	30-Day	7-Day	30-Day
Statewide (Medicaid Managed Care, HARP, HIV SNP, and CHPlus)		32%	44%	33%	46%
Age	13-17	28%	38%		
	18-44	33%	45%		
	45+	34%	46%		
Race	Asian/Pacific Islander	26%	36%		
	Black	27%	39%		
	Hispanic	33%	44%		
	White	40%	53%		
	Unknown	30%	40%		
	Other	32%	44%		
Sex	Male	32%	44%		
	Female	34%	47%		
Disability	Yes (SSI)	38%	53%		
	No (Not SSI)	32%	43%		

Metric 9.2: Follow-Up After Emergency Department Visit for Mental Illness - 7 & 30 day				
Measure Description: Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days. **Source:** QARR				
	Baseline Rate (2021)		Target Rate	
	7-Day	30-Day	7-Day	30-Day
Statewide (Medicaid Managed Care, HARP, HIV SNP, and CHPlus)	52%	67%	54%	69%

Age	6-17	61%	76%		
	18-44	49%	62%		
	45+	47%	61%		
Race	Asian/Pacific Islander	53%	68%		
	Black	47%	62%		
	Hispanic	53%	68%		
	White	57%	72%		
	Unknown	51%	64%		
	Other	49%	64%		
Sex	Male	49%	63%		
	Female	55%	70%		
Disability	Yes (SSI)	55%	73%		
	No (Not SSI)	51%	64%		

Objective 10: Improve access to and quality of dental care

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

Background: Oral health goes hand in hand with a person's overall health; diseases and conditions of the mouth directly impact the health of the entire body. Dental caries is the most prevalent chronic disease among US children, with over 40% of all children experiencing tooth decay by the time they reach kindergarten. Nationally, publicly insured children and adults are less likely to have had a dental visit in the past year than privately insured patients. In 2021, only 29.8% of New York Medicaid enrollees had a dental visit within the last year. Dental provider capacity is strained with only 84 dentists per 100,000 New Yorkers.[xxxix]

Health Equity: Notable disparities in oral health exist across economic and racial groups. Low income and lack of private health insurance are strongly associated with unmet oral care. Low-income adults have mild to moderate untreated caries twice as frequently and have severe untreated caries three times as frequently as high-income adults.[xl] Non-Hispanic Black and Mexican American children and adults are nearly twice as likely to have untreated cavities than non-Hispanic white children and adults. [xli]

Intervention(s): "Reduce dental caries among children" is a goal of the Prevention Agenda. To achieve this goal, NYSDOH is working toward three objectives: (1) Increase the percentage of New York State residents served by community water systems that have optimally fluoridated water by 9% to 77.5%, (2) Decrease the percentage of children ages 1-17 years who had decayed teeth or cavities in the past year by 20% to 6.7%, and (3) Increase the percentage of children ages 1-17 years who had one or more preventive dental visits in the past year by 10% to 85.4%.[xlii]

NYSDOH is also working to improve access to dental care for Medicaid and CHPlus members. School Based Health Centers (SBHCs) bring dental care to directly to students in high-risk areas. There are currently SBHCs in 113 schools, covering primary through high school, throughout the State.[xliii] The Medicaid and CHPlus program covers teledentistry when clinically appropriate. Members can receive care through real-time audio-visual communication and the transmission of recorded information like charting, radiographs, and digital impressions. Medicaid and CHPlus allows non-dentist providers to apply fluoride varnish in primary care setting. These services facilitate quicker, less costly, and more convenient care.

Patients with traumatic brain injury (TBI) or intellectual and developmental disabilities (I/DD) often face barriers to receiving dental care. To improve access, NYSDOH increased reimbursement for dental providers serving the TBI and I/DD populations, including a 20% enhancement over the fee schedule for all services provided by private practice dentists, separate reimbursement for multiple forms of sedation, and higher allowable units for dental surgery provided in ambulatory surgery centers. [xliv]

Metric 10.1: Topical Fluoride for Children		
Measure Description: The percentage of members 1–20 years of age who received at least two topical fluoride applications during the Measurement Year. **Source:** QARR		
	Baseline Rate	Target Rate
Statewide (Mainstream Medicaid Managed Care, HIV SNP, and CHPlus)	Not Available (to be reported in 2023)	To be calculated after first reporting period

Metric 10.2: Annual Dental Visit		
Measure Description: The percentage of adult members 21–64 years of age who had at least one preventive dental visit during the measurement year. **Source:** Medicaid Claims Data		
	Baseline Rate (2021)	Target Rate
Statewide (Mainstream Managed Care, HARP, HIV SNP, and Medicaid Fee-For-Service)	20%	22%

Plan Type	MMC (Mainstream, HARP, HIV SNP)	22%	
	FFS	3%	
Race	Asian/Pacific Islander	23%	
	Black	17%	
	Hispanic	20%	
	White	20%	
	Unknown	19%	
	Other	19%	
Sex	Male	16%	
	Female	23%	
Disability	Yes (SSI)	18%	
	No (Not SSI)	20%	

Objective 11: Improve access to and quality of maternal healthcare

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

Background: New York State Medicaid Perinatal Care Standards outline the comprehensive maternal health policy applicable to all Medicaid perinatal care providers, including medical care facilities or public or private not-for-profit agencies or organizations, physicians, licensed nurse practitioners, and licensed midwives practicing on an individual or group basis, and managed care plans that contract with these providers. The standards include guiding principles which state that services must be delivered in a high-quality, person-centered, cohesive, and comprehensive manner and all providers must adopt a clinical practice philosophy that: is consistent with current standards of care; applies a health equity framework to eliminate racial and ethnic inequities, implicit bias, and racism; demonstrates cultural humility and sensitivity; promotes timely access; promotes comprehensive biopsychosocial risk assessment; uses an integrated care model; commits to continuous quality improvement. The postpartum Medicaid coverage period in NYS increased from 60 days to 12 months, effective March 2023. All pregnant Medicaid members who are State residents receive the same length of coverage at the conclusion of a pregnancy, regardless of immigration status or how their pregnancy ends. NYS Medicaid's policies and coverage expansions can have a powerful impact on maternal health in the State. Key maternal health indicators include maternal mortality rates and postpartum depression: New York ranks twenty-second in the nation for maternal mortality with

a mortality rate of 21.7 deaths per 100,000 live births (using 2018-2021 data)[xlv]; the postpartum depression rate in NYS was 10.1% in 2020[xlvi].

Health Equity: The NYSDOH's Maternal Mortality Review Board tracks pregnancy-associated deaths in the State and shows that Black, non-Hispanic people who give birth are five times more likely to die of a pregnancy related cause than white non-Hispanic people. Discrimination and implicit bias play a significant role in those deaths.[xlvii] Postpartum depression is common, impacting about one in seven women, and is more likely to occur in adolescent mothers and those who live in urban settings. A focus on prevention, as well as increased attention during the postpartum period can provide needed support.[xlviii]

Intervention(s): NYSDOH's Prevention Agenda includes an aim to promote healthy women, infants, and children. To measure this, the Prevention Agenda tracks several indicators. Maternal mortality, postpartum depression screening, and talking to a provider about a healthy pregnancy are among the indicators being tracked.[xlix] [l]

Within New York's Medicaid program, several initiatives have recently been implemented to improve maternal healthcare. In recent years, New York has prioritized maternal health with updating policies and expanding of Medicaid prenatal and postpartum benefits.

In 2022, the NYS Medicaid Perinatal Care Standards[li] were updated to provide clarifying guidance and requirements on perinatal care for all Medicaid providers serving pregnant and postpartum individuals, with an explicit focus on health equity, health disparities, and racial bias. That same year, increased coverage of maternal depression screening and perinatal and postpartum remote patient monitoring[lii] were implemented, and in 2023, Medicaid coverage was extended from a 60-day postpartum period to a full year following pregnancy.[liii] The NYSDOH continues to promote Project TEACH (Training and Education for the Advancement of Children's Health), which provides consultations with reproductive psychiatrists, referrals to services, and education for both providers and mothers.[liv] NYSDOH will soon expand doula, midwifery, and other important services for mothers and newborns.[lv]

Metric 11.1: Postpartum care			
Measure Description: The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery. **Source:** QARR			
		Baseline Rate (2021)	Target Rate
Statewide (Medicaid Managed Care, HARP, HIV SNP and CHPlus)		81%	82%
Age	0-18	80%	
	19-29	80%	
	30-39	83%	

	40+	84%	
Race	Asian/Pacific Islander	91%	
	Black	72%	
	Hispanic	76%	
	White	80%	
	Other	67%	
	Unknown	86%	
Sex	Male	N/A	
	Female	81%	
Disability	Yes (SSI)	75%	
	No (non-SSI)	81%	

Objective 12: Improve access to and quality of Home and Community Based Services

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

Background: Home and Community-Based Services (HCBS) help individuals with daily living, social skills, education, and employment to achieve their personal goals and engage with their community. The aging population, COVID-19 pandemic, and heightened emphasis on person-centered care have increasingly shifted services out of traditional settings, reinforcing the need for high quality HCBS.

Health Equity: HCBS programs generally serve targeted, vulnerable groups such as those with disabilities or mental illness. Eligibility requirements vary across states and programs which can inadvertently exclude people from receiving necessary support through biased policy. Disparities in access can widen through insufficient provider capacity, inaccessible application processes, biased authorization and assessment tools, and the lack of culturally appropriate care.

Intervention(s): HCBS are available to eligible individuals through many programs, including:

- Managed Long-Term Care
- Health and Recovery Plans (Adult Behavioral HCBS and Community Oriented Recovery and Empowerment Services)

- Traumatic Brain Injury 1915c Waiver
- Nursing Home Transition & Diversion 1915c Waiver
- Community First Choice Option
- Children's HCBS 1915c Waiver
- OPWDD HCBS 1915c Waiver
- Money Follows the Person Demonstration (described in Objective 2)
- Child Health Plus Enrollees, not Eligible for Medicaid (as of January 1, 2024)

Each program is uniquely designed to meets the needs of the individual and support them through integrated care. Specific services may include care coordination, skill building, family and caregiver support services, crisis and planned respite, prevocational services, supported employment services, community advocacy and support, youth support and training, and non-medical transportation.

NYSDOH also evaluates the quality of its HCBS. MLTC surveys members to measure satisfaction and HARP plans must report on HCBS-related measures. To support HCBS during the public health emergency, the American Rescue Plan Act of 2021 increased the federal medical assistance percentage for certain Medicaid HCBS expenditures by 10 percent. States may spend the funds through March 31, 2025. NYSDOH worked collaboratively with other state agencies to create a spending plan centered on (1) Supporting & Strengthening the Direct Care Workforce, (2) HCBS Capacity, Innovations and Systems Transformation, and (3) Digital Infrastructure Investment. The 43 initiatives across these categories will enhance the critical services delivered through HCBS.

Metric 12.1: Members in 1915c Children's Waiver Program with Physical Exam		
Measure Description: Proportion of Participants, who were enrolled in the Waiver Program for more than 1 day, per Health Home that has had an Annual Physical Exam or Wellness Exam within the Waiver Year (04/01/2022 - 03/31/2023). (Measure G-28) **Source:** Waiver Participant Roster, Medicaid Claims Data		
	Baseline Rate (2022-2023)	Target Rate
Statewide (Medicaid Children's Waiver Enrollees)	56%	85%

Objective 13: Improve access to and quality of patient-centered primary care

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

Background: Primary care is the cornerstone of the managed care model. New York's Medicaid managed care and CHPlus plans aim to create strong relationships between members and the primary care provider they select. This relationship fosters access to preventive care, like screenings and immunizations as well as coordinated and unduplicated access to specialty care. The majority of NYS Medicaid members select their PCP within their plan's network, and a PCP is assigned to members who do not select one.

Health Equity: Evidence demonstrates that Medicaid enrollees are comparatively limited in accessing primary care. For example, New Yorkers enrolled in commercial managed care plans have higher screening rates for colorectal, cervical, and breast cancer, as compared to Medicaid managed care enrollees[lvi] and higher well-child visit rates, as compared to Medicaid managed care and CHPlus enrollees. Medicaid enrollees are also more likely to use the emergency room (ER), in part because of limited access to adequate primary care.[lvii] Additionally, factors like disability status[lviii] and language[lix] can negatively impact access to care.

Intervention(s): Over the course of 2022 and 2023, NYS Medicaid implemented a multi-million dollar investment in primary care by benchmarking Medicaid's fee-for-service physician reimbursement rates to 80% or Medicare and significantly increasing reimbursement for Nurse Practitioners and Midwives. Prior to these investments, the fee schedules had not been meaningfully changed since 2009. NYSDOH anticipates plans' negotiated rates to increase as a reflection of the fee schedule increases. In turn, NYSDOH expects an increase in the number of primary care providers participating with Medicaid as well as increased capacity among participating providers to see more Medicaid members. As a result, members will have increased access to primary care and will be more likely to utilize it. The Patient Centered Medical Home program (described in objectives 2 and 8) helps ensure that the primary care received by Medicaid and CHPlus members offers a high degree or care coordination and leads to positive quality outcomes.

Metric 13.1: Proportion of members who utilize primary care			
Measure Description: Proportion of all Medicaid and CHP members who used primary care in the calendar year. **Source:** Medicaid Claims Data; Medicaid Enrollment Data			
		Baseline Rate (2022)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP, HIV SNP, MLTC, and Fee-for-Service Medicaid) *CHPlus not available at baseline*		66%	73%
Plan Type	Medicaid Managed Care	75%	
	HARP	83%	

	HIV SNP	84%	
	MLTC (Partial Capitation, PACE, MAP)	78%	
	Medicaid FFS	31%	
Age	0-17	82%	
	18-44	56%	
	45+	64%	
Race	Asian/Pacific Islander	75%	
	Black	63%	
	Hispanic	63%	
	White	70%	
	Unknown or Other	61%	
Sex	Male	62%	
	Female	70%	
Disability	Yes (Administrative Definition)	86%	
	No (Administrative Definition)	62%	

Objective 14: Improve access to and quality of care for infants and children

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

Background: NYSDOH has long demonstrated its commitment to healthcare for children and has implemented one of the most comprehensive Children's Health Insurance Programs in the country. The NYS CHPlus program provides subsidized coverage for children up to 400% federal poverty line (FPL), under the age of 19. The program currently covers nearly 400,000 children in NYS[lx]. In 2020, 97.5% of children in New York had health insurance.[lxi] The NYSDOH is committed to providing holistic, high-quality care that ensures every child has a healthy start to pave the way for healthy adulthood.

Health Equity: Pediatric care is essential to every child's growth and development. Adverse childhood experiences and social determinants of health can make some children more vulnerable than others, influencing their immediate and long-term wellbeing. For example, racism has been linked to birth disparities, mental health problems in children and adolescents, and infant mortality.[lxii] These factors must be incorporated into care for infants and children to promote their best health.

Intervention(s): Perinatal & Infant Health and Child & Adolescent Health are focus areas of the current Prevention Agenda, drawing down from the Maternal and Child Health Services Block Grant (Title V) Program to promote the local action and cross-sector collaboration in its efforts to support children and families. Specific goals focus on infant mortality, breastfeeding, social-emotional development, supports for children with special healthcare needs, and dental caries. These efforts work in conjunction with many other areas of the Prevention Agenda to ensure access to and quality of care for infants and children.[lxiii]

The Managed Care Program also prioritizes postpartum and infant care. Medicaid Managed Care and Child Health Plus plans are required to cover lactation counseling and Medicaid recently expanded the eligible lactation counselor certifications to support parents and infants through successful breastfeeding. Doula services are a currently covered benefit via a pilot program. The NYSDOH is seeking a State Plan Amendment to cover prenatal, labor and delivery, and postpartum doula services.[lxiv] As mentioned in Objective 11, Medicaid and CHPlus coverage was recently extended to a full year following pregnancy.

A wide range of programs continuously support children as they grow. Early Intervention provides therapeutic and support services to children under age three with disabilities. The Preschool/School Supportive Health Services Program continues these supports through age 21. New York State Medicaid implements Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit through the Child Teen Health Program (CTHP). CTHP ensures children receive critical screenings, well care exams, immunizations, mental healthcare, and dental care. It also uses a holistic, person-centered approach to support a child with an understand of the social context that may affect their wellbeing.[lxv]

Children in foster care are categorically eligible for Medicaid. They receive comprehensive health evaluations and individualized plans of care to ensure their needs are met. As part of the Children's Medicaid Redesign, most children under the care of Volunteer Foster Care Agencies (VFCAs) are enrolled in Medicaid Managed Care. Medicaid Managed Care plans must comply with the standards set forth in the Medicaid Managed Care Organization Children's System Transformation Requirements and Standards. VFCAs are licensed as 29-I Health Facilities and provide mandatory core health-related services to youth in their care with a trauma-informed lens. 29-I services are covered in the CHPlus benefit package as well in order to cover the child population not eligible for Medicaid.

In 2019, the Center for Medicare and Medicaid Innovation awarded the NYSDOH a seven-year, $16 million grant to implement the Integrated Care for Kids (InCK) Model. This model aims to improve child health through early identification and treatment combined with integrated care coordination through state, provider, and community partnership. New York's InCK program with Montefiore Medical Center streamlines care coordination while providing high quality care for a medically complex and underserved population in the Bronx.

As of 2022, nearly all Medicaid MCOs had VBP contracts with a children's arrangement, which includes quality measurement for children enrolled in both Medicaid and CHPlus. These arrangements emphasize value over volume with a dedicated focus on the healthy growth and development of children. They follow the "North Star" framework of goals, key indicators, and strategies for high-value children's healthcare. All plans with a children's arrangement report on the Child Quality Measure Set to demonstrate their performance.[lxvi]

Metric 14.1: Well-Child Visits in the First 30 Months of Life					
Measure Description: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months. **Source:** QARR					
		Baseline Rate (2021)		Target Rate	
Statewide (Mainstream Medicaid Managed Care, HIV SNP, and CHPlus)		72%		73%	
		First 15 Months	15-30 Months	First 15 Months	15-30 Months
Statewide (Mainstream Medicaid Managed Care, HIV SNP and CHPlus)		67%	78%		
Race	Asian/Pacific Islander	78%	83%		
	Black	60%	71%		
	Hispanic	59%	79%		
	White	64%	79%		
	Unknown	70%	79%		
	Other	58%	79%		
Sex	Male	67%	78%		
	Female	67%	78%		
Disability	Yes (SSI)	49%	83%		
	No (Not SSI)	67%	78%		

Metric 14.2: Child and Adolescent Well-Care Visits
Measure Description: Assesses children 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/Gyn practitioner during the measurement year. **Source:** QARR

		Baseline Rate (2021)			Target Rate		
Statewide (Medicaid Managed Care, HIV SNP, and CHPlus)		70%			71%		
Age Group		3-11	12-17	18-21	3-11	12-17	18-21
Statewide (Medicaid Managed Care, HARP, HIV SNP, and CHPlus)		76%	71%	49%			
Race	Asian/Pacific Islander	83%	78%	61%			
	Black	72%	66%	45%			
	Hispanic	80%	74%	52%			
	White	74%	70%	45%			
	Unknown	77%	72%	49%			
	Other	77%	70%	50%			
Sex	Male	76%	70%	42%			
	Female	76%	72%	55%			
Disability	Yes (SSI)	77%	70%	50%			
	No (Not SSI)	76%	71%	49%			

Metric 14.3: Follow-Up Care for Children Prescribed ADHD Medication

Measure Description: The two rates of this measure assess follow-up care for children prescribed an ADHD medication:

Initiation Phase: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

Continuation and Maintenance Phase: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.

Source: QARR

		Baseline Rate (2021)		Target Rate	
		Initiation	Continuation	Initiation	Continuation
Statewide (Mainstream Medicaid Managed Care, HIV SNP, and CHPlus)		53%	62%	55%	63%
Race	Asian/Pacific Islander	58%	79%		
	Black	51%	61%		

	Hispanic	58%	67%		
	White	51%	60%		
	Unknown	54%	62%		
	Other	56%	61%		
Sex	Male	53%	61%		
	Female	53%	62%		
Disability	Yes (SSI)	55%	64%		
	No (Not SSI)	53%	61%		

Objective 15: Improve access to and quality of chronic disease management

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

Background: Chronic diseases, including heart disease, cancer, diabetes, stroke, and arthritis, are the leading causes of disability and death in NYS and throughout the United States. More than 40% of New York adults suffer from a chronic disease.[lxvii] In NYS, an estimated 1 in 10 adults (1.65 million adults) and 1 in 12 children (nearly 360,000 children) have asthma[lxviii] and an estimated 1.58 million adult New Yorkers (10.3%) have diagnosed diabetes.[lxix]

Health Equity: Chronic diseases have sociodemographic patterns, impacting those with lower income and education at a higher rate.[lxx] Diagnosed diabetes is more prevalent among Black people, those enrolled in Medicare or Medicaid, those with a disability, and those with lower household income.[lxxi] Similarly, asthma disproportionately impacts racial and ethnic minority groups and those with lower income. Structural and environmental factors can drive or exacerbate these disparities.[lxxii]

Intervention(s): NYS Medicaid has programs in place to provide tailored managed care for certain chronic disease populations, as well as chronic disease management and education programs in place for all Medicaid members.

HIV SNPs, which offer the same benefits as mainstream Medicaid managed care plans as well as specialized services, are available for Medicaid members with HIV/AIDS. Members in HIV SNPs can select an HIV Specialist to serve as their primary care provider. Over 15,000 Medicaid members were enrolled in HIV SNPs as of July 2023.[lxxiii] NYS Medicaid's Health Home program (described in objective 20) also offers comprehensive care management for members

with chronic health problems who meet certain eligibility criteria. Through the "In Lieu of Services" benefit, NYS Medicaid offers Medically Tailored Meals (MTMs) for members with chronic conditions to combat food insecurity and promote healthy, dietician-designed meals to meet a member's unique needs.[lxxiv]

Members with chronic diseases are encouraged to participate in self-management education, including the Chronic Disease Self-Management Program (CDSMEP) for Medicaid members diagnosed with arthritis, Diabetes Self-Management Training (DSMT), Diabetes Prevention Program (DPP), and Asthma Self-Management Training (ASMT). These programs provide education and tools to help adults manage chronic conditions and are proven to help people manage symptoms and improve their quality of life.

NYSDOH also develops fact sheets for Medicaid and CHPlus members to provide important information on various health topics, including several focused on chronic disease management.[lxxv] MCOs must report annually on a suite of chronic disease measures via QARR.

Metric 15.1: Viral Load Suppression		
Measure Description: The percentage of Medicaid enrollees confirmed HIV-positive who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. **Source:** QARR		
	Baseline Rate (2021)	Target Rate
Statewide (Mainstream Medicaid Managed Care and CHPlus)	73%	75%

Metric 15.2: Hemoglobin A1c Control for Patients with Diabetes ***This measure is also known as "Glycemic Status Assessment for Patients With Diabetes" (measure name change in measure year 2024)**			
Measure Description: Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). **Source:** QARR			
		Baseline Rate (2021)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP, HIV SNP)		55%	57%
Plan Type	Medicaid	55%	
	HARP	52%	
	HIV SNP	67%	
Age	18-44	50%	
	45-64	56%	

	65+	60%	
Race	Asian/Pacific Islander	62%	
	Black	47%	
	Hispanic	55%	
	White	54%	
	Unknown	58%	
	Other	47%	
Sex	Male	53%	
	Female	57%	
Disability	Yes (SSI)	56%	
	No (Not SSI)	55%	

Metric 15.3: Asthma Medication Ratio - Both Adult and Child (5-64)					
Measure Description: Assesses adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. **Source:** QARR					
		Baseline Rate (2021)		Target Rate	
Statewide (Medicaid Managed Care, HARP, HIV SNP, and CHPlus)		55%		56%	
		Age 5-18	Age 19+	Age 5-18	Age 19+
Statewide (Medicaid Managed Care, HARP, HIV SNP, and CHPlus)		65%	50%		
Race	Asian/Pacific Islander	72%	62%		
	Black	60%	42%		
	Hispanic	62%	45%		
	White	72%	51%		
	Unknown	66%	53%		
	Other	65%	47%		
Sex	Male	66%	45%		
	Female	65%	51%		
Disability	Yes (SSI)	65%	45%		
	No (Not SSI)	66%	51%		

Objective 16: Increase utilization of preventive healthcare services

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

Background: Not all conditions are preventable, however NYSDOH puts significant work into promoting the services and healthy lifestyles that prevent disease. Services such as vaccines, screenings, annual physical exams, and patient education are vital to prevent severe health conditions and reduce healthcare costs.

Health Equity: Social factors affect the likelihood of an individual developing certain health conditions and can compound each other. For example, the tobacco industry tailors marketing to target specific groups. Social conditions increase the likelihood of tobacco use and secondhand exposure. These factors lead to disparities in tobacco use and its related health conditions. [lxxvi]

Social factors can also prevent people from engaging with care. Patients who perceive discrimination from healthcare providers related to their insurance type, socioeconomic status, and race/ethnicity are less likely to use preventative services like cholesterol testing, hemoglobin A1c testing and eye exams for diabetes, and flu shots.[lxxvii]

Intervention(s): The Vaccines for Children Program provides vaccines at no cost to children who are Medicaid or, Medicaid-expansion CHIP enrolled underinsured, or uninsured. This program reduces the cost barrier to immunization and allows children to easily receive immunizations at physicians' offices and public health clinics.[lxxviii] Medicaid Managed Care and CHPlus covers preventive services with no cost sharing, and plans outreach to members directly to promote maintenance of well-child and immunization schedules.

NYS Cancer Services Program offers breast, cervical, and colorectal cancer screenings and diagnostic services at no cost to New Yorkers who are uninsured or underinsured.[lxxix] The percentage of adults who receive a colorectal cancer screening based on the most recent guidelines, aged 50-64 years has significantly improved toward to 71.8% in 2021 and exceeded its Prevention Agenda goal of 66.3% by 2024.[lxxx] However, the colorectal screening rate among Medicaid enrollees trails behind at 61% in 2021.

NYS Medicaid Managed Care Programs cover a comprehensive smoking cessation benefit, which includes counseling and pharmacotherapy to reduce tobacco use. The benefit is offered without cost sharing, prior authorization requirements, or limits on quit attempts to ensure it is readily available when individuals seek assistance. Medicaid also covers over the counter products like nicotine patches, gum, and lozenges.

NYSDOH also invests in primary care, an essential avenue for preventative care. The Fiscal Year 2024 NYS Executive Budget committed $419 million gross investment in preventative and primary care.

As described in Objective 14, EPSDT benefits ensure children under age 21 receive critical preventive care such as vaccinations and screenings. Services are delivered in the home or community-based settings whenever possible to make this care more accessible.

In addition, Medicaid covers all Grade A and B preventive services recommendations from the U.S. Preventive Services Task Force (USPSTF) without cost sharing. This includes coverage of various cancer, mental health, and sexually transmitted disease screenings, tobacco cessation interventions, and preventive medications. NYS Medicaid is responsive to USPSTF recommendations and updates its policy as new recommendations are published to ensure members have access to high-quality, evidence-based preventive care.

Metric 16.1: Colorectal Cancer Screening			
Measure Description: Assesses adults 45–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years. **Source:** QARR			
		Baseline Rate (2021)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP and HIV SNP)		61%	62%
Age	45-64	60%	
	65+	64%	
Race	Asian/Pacific Islander	72%	
	Black	51%	
	Hispanic	63%	
	White	56%	
	Unknown	63%	
	Other	59%	
Sex	Male	56%	
	Female	64%	
Disability	Yes (SSI)	59%	
	No (Not SSI)	61%	

Metric 16.2: Childhood Immunization Status (Combo 10)

Measure Description: The percentage of children 2 years of age who had combo 10 vaccines by their second birthday (DTAP, IPV, MMR, HIB, Hepatitis B and VZV) **Source:** QARR			
		Baseline Rate (2021)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HIV SNP, and CHPlus)		42%	43%
Race	Asian/Pacific Islander	64%	
	Black	30%	
	Hispanic	53%	
	White	32%	
	Unknown	42%	
	Unknown	42%	
Sex	Male	44%	
	Female	41%	
Disability	Yes (SSI)	31%	
	No (Not SSI)	42%	

Objective 17: Prevent chronic disease

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

Background: The prevalence of chronic disease in NYS as well as the documented disparities that exist were discussed in objective 15; in addition to promoting management of chronic disease, the NYSDOH has a robust prevention plan with four major focus areas. The "Prevent Chronic Disease Action Plan" focuses on 1) healthy eating and food security, 2) physical activity, 3) tobacco prevention, and 4) chronic disease preventive care and management.[lxxxi] In addition to these focus areas, the CDC recommends additional preventive measures including proactive oral health, sufficient sleep, and knowing family history of disease.[lxxxii] The CDC estimates 90% of the nation's healthcare expenditures are for people with chronic and mental health conditions.[lxxxiii]

Health Equity: Prevalence of multimorbidity has been increasing over the last twenty years though there has not been an observed narrowing in the disparity gap among Black and White individuals. Taking an early-life prevention approach may be needed to reduce disparities.[lxxxiv] Disparities exist in preventive healthcare services and a better understanding of the unique barriers that minority groups face in using or engaging with prevention strategies is needed to build meaningful interventions.[lxxxv]

Intervention(s): Across the Prevention Agenda focus areas, the NYSDOH has outlined multiple interventions aimed at increasing food security and access, improving environments for physical activity, preventing tobacco use initiation, and promoting screenings and early detection of disease for all New Yorkers. Additionally, the State has developed a comprehensive "Ending the AIDS Epidemic" (ETE) plan as well as a Hepatitis C ("Hep C") Elimination Plan that addresses social and structural factors related to Hep C screening and treatment. NYS aims to eliminate Hep C as a public health problem by 2030. One intervention is to implement universal Hep C screening for all pregnant women, which will reduce vertical transmission from mother to child.[lxxxvi]

Metric 17.1: Hep C Elimination Measure -- Universal screening for pregnant people		
Measure Description: Proportion of Medicaid members with live births in the calendar year who had a Hep C screening. **Source:** Medicaid Claims Data		
	Baseline Rate (2022)	Target Rate
Statewide (Pregnant Mainstream Medicaid Managed Care, HARP, HIV SNP, and Fee-for-Service members)	72%	79%

Objective 18: Promote data-driven Medicaid oversight and health plan accountability

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

Background: NYS Governor Kathy Hochul implemented a NYS Government Transparency Initiative aimed at improving transparency and increasing accountability throughout NYS government. The NYSDOH developed a transparency plan, outlining specific initiatives to better communicate its work, increase data availability, and promote public use of the available data. Specific initiatives include 1) expanded public engagement via consumer facing materials, participation from DOH leaders at community meetings and forums, engagement in social

media, and more, 2) increased transparency through accessible data, including new publicly available datasets on DOH websites and more transparency about the Freedom of Information Law (FOIL) process, 3) promotion of opportunities for the public to participate in decision-making processes, and 4) a review of record retention and disposal processes to advance transparency and accountability.[lxxxvii] In addition to promoting the availability and use of NYSDOH data publicly, the NYS Medicaid program is also undertaking data submission system renovations to increase ease of use for providers and health plans, and improve the quality of collected data, such as encounter data and provider network data.

Health Equity: Quantitative information is essential to achieving health equity. It allows policymakers to identify disparities, pinpoint groups which might benefit from intervention, and measure progress toward goals. Policymakers must also critically examine their data collection and analysis to check for any implicit bias affecting the outputs.

Intervention(s): NYSDOH'S Division of Health Plan Contracting and Oversight (DHPCO) works diligently on Medicaid Managed Care and CHPlus Plan oversight. They ensure compliance with policies and regulations, monitor plan performance, review contracts, and handle complaints. Their work is essential to promoting health plan accountability and transparency.

NYSDOH'S Division of Data Analytics and Services created various "databooks," highly interactive visualizations which allow staff to easily access data. A quality databook is currently under development to monitor the metrics in this Quality Strategy and other measures identified as key performance indicators. The quality databook will contain a variety of filters such as demographic categories, NYSDOH programs, and health plan enrollment to give better insight into specific cohorts.

To promote transparency into NYSDOH and health plan performance, NYS also makes a wide range of data publicly available on its website, Health Data NY. The Prevention Agenda Dashboard shares state and county level detail on the Prevention Agenda indicators. The Public Health Unwind Emergency Unwind Dashboard monitors insurance coverage with the recent end of continuous enrollment. The Managed Care Regional Consumer Guides empower New Yorkers with detail about the quality of care given by managed care plans.

Incomplete race and ethnicity data has been a barrier to fully understanding disparities within NYS Medicaid and CHPlus programs; however, recent adjustments to how demographic questions are phrased within the NY State of Health enrollment tool has led to a notable improvement in race and ethnicity data among those enrolled in Qualified Health Plans. These same changes are expected to improve completeness of race and ethnicity data within the Medicaid and CHPlus programs as more manual enrollments are required in the post-PHE period.

Metric 18.1: Completeness of Race/Ethnicity Data
Measure Description: Proportion of Medicaid members with Race/Ethnicity recorded on their enrollment file.

Source: Medicaid Enrollment Data			
		Baseline Rate (2022)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP, HIV SNP, MLTC, and Fee-for-Service Medicaid)		74%	81%
Plan Type	Medicaid Managed Care	72%	
	HARP	82%	
	HIV SNP	87%	
	MLTC (Partial Capitation, PACE, MAP)	90%	
	Medicaid FFS	78%	
Age	0-17	75%	
	18-44	70%	
	45+	79%	
Sex	Male	74%	
	Female	76%	
Disability	Yes (Administrative Definition)	84%	
	No (Administrative Definition)	73%	

Objective 19: Promote member safety

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

Background: Patient safety can include protections against adverse events in healthcare like hospital acquired infections and contraindicated prescribing, protections against biased healthcare delivery, assurances of basic rights to healthcare, and mechanisms in place to file complaints and grievances when safety concerns arise. The World Health Organization's (WHO's) "Medication Without Harm" initiative addresses unsafe medicine practices, a leading cause of injury in health systems globally. WHO developed a framework that defines key action areas to improve patient safety: healthcare professionals can improve patient safety with

education and training, communication and teamwork, capability at point of care, and incident reporting and learning.[lxxxviii]

Health Equity: Patient safety is not equal across gender and ethnic groups in primary care[lxxxix] and other domains of care[xc] and may be related to implicit bias in healthcare delivery.[xci][xcii]

Intervention(s): The NYSDOH ensures patient safety through health plan and provider oversight, credentialing, and through the promotion of safe practices. All New Yorkers, including Medicaid and CHPlus members, are empowered to make informed decisions about the healthcare providers they select, and the New York State Physician Profile makes important provider information easily searchable. The search tool allows users to publicly find individual providers, learn about their education, Board Certifications, and any legal actions taken against the provider.[xciii]

Additionally, NYS Medicaid has several avenues for members to register concerns and complaints against providers and health plans, including a complaint helpline (1-800-206-8125). A Managed Care Bill of Rights outlines the rights and protections afforded to Medicaid managed care enrollees.[xciv]

In 2023, NYS Medicaid launched its pharmacy program, NYRx. The program transitioned the pharmacy benefit from the managed care plans to a single fee-for-service formulary for Medicaid members. In doing so, Medicaid is promoting patient safety and equity by established a single, uniform list of covered drugs with standardized and consistent rules and regulations. All mainstream Medicaid members now have access to the same pharmacy network, and an improved process for getting needed medications.[xcv]

Metric 19.1: Pharmacotherapy for Opioid Use Disorder

Measure Description: Assesses the percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members aged 16 and older that continue for at least 180 days (6 months).

Source: QARR

		Baseline Rate (2022)	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP, HIV SNP, and CHPlus)		32%	33%
Age	18-44	30%	
	45-64	35%	
	65+	24%	
Race	Asian/Pacific Islander	28%	
	Black	26%	
	Hispanic	31%	

	White	33%	
	Unknown	31%	
	Other	29%	
Sex	Male	31%	
	Female	32%	
Disability	Yes (SSI)	32%	
	No (Not SSI)	31%	

Objective 20: Reduce unnecessary ER visits and hospitalizations

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

Background: Emergency rooms (ERs) are often used when people do not have access to convenient low-acuity care, like primary care or walk-in clinics, and when unmanaged chronic conditions lead to emergent episodes. These situations increase healthcare costs and strain resources. NYSDOH aims to build a healthcare system that addresses health conditions in lower care settings before they lead to unnecessary ER visits and inpatient admissions.

Health Equity: Social determinants of health can drive a person's use of higher care settings. For example, food insecurity impairs chronic disease management and is associated with increased ER visits and hospitalizations. 9.6% of New Yorkers did not have access to a reliable source of food during the past year and may be at risk of avoidable acute care if poor access to nutritious food worsens their underlying health conditions.[xcvi]

Intervention(s): As mentioned in Objective 8, the DSRIP program concluded in 2020, but its legacy lives on. A core DSRIP goal was to reduce avoid hospital use. At the end of the program, NYS developed a VBP Roadmap outlining the strategy for a more efficient, high quality, and community-based healthcare system.

The Health Home program provides comprehensive care management to Medicaid members with two or more chronic conditions or a single qualifying chronic condition. The model creates a symbolic "home" of linked medical, behavioral, and social care providers. Health Homes coordinate the member's health services and social supports, which leads to more consistent care and fewer emergency room visits.

The Medicaid Accelerated eXchange (MAX) program supports interdisciplinary teams achieve sustainable reductions in hospital admission and emergency department use through collaborative, educational workshops. The work of over 100 MAX Action Teams has led to greater understanding of the drivers of high utilization and the implementation of effective pathways to assist patients at many medical centers throughout the State. [xcvii]

Among several social care initiatives the NYSDOH has implemented, Medically Tailored Meals, Street Medicine, and Medical Respite target social determinants of health. Seven Medicaid Managed Care organizations offer Medically Tailored Meals. Through this benefit, members receive home delivery of meals specifically designed for their medical needs by a Registered Dietician. This program improves health outcomes while decreasing ER visits and the associated cost of care.[xcviii] Street Medicine and the Medical Respite Program provide care to the homeless population; these programs also aim to reduce unnecessary ER visits and hospitalizations.

The CMS Emergency Triage, Treat, and Transport (ET3) Model enables ambulances teams responding to a 911 call to treat in place or transport to an alternative destination, such as an urgent care center, when medically appropriate. This flexibility reduces healthcare costs and avoids unnecessary ER visits. Although the federal program ends December 31, 2023, NYS is pursuing a State Plan Amendment to sustain and fund treatment in place.

Metric 20.1: Follow-Up After Hospitalization for Mental Illness - 7 & 30 day

Measure Description: Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider within 7 and 30 days.

Source: QARR

		Baseline Rate (2021)		Target Rate	
		7-Days	30-Days	7-Days	30-Days
Statewide (Medicaid Managed Care, HARP, HIV SNP, and CHPlus)		63%	79%	64%	80%
Plan Type	Medicaid and CHPlus	66%	80%		
	HARP	58%	77%		
	HIV SNP	37%	56%		
Age	6-17	77%	91%		
	18-44	61%	77%		
	45+	58%	75%		
Race	Asian/Pacific Islander	68%	82%		
	Black	56%	74%		
	Hispanic	64%	80%		

	White	67%	82%		
	Unknown	65%	78%		
	Other	60%	76%		
Sex	Male	58%	74%		
	Female	68%	83%		
Disability	Yes (SSI)	61%	80%		
	No (Not SSI)	64%	78%		

Objective 21: Ensure members are able to receive care in the least restrictive setting possible

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

Background: Supporting members in their communities includes promoting HCBS, encouraging the right level and setting for acute care, and increasing access to early, preventive care that can reduce preventable hospital stays. Where possible, providing services in HCBS (as described in objectives 4 and 12) has benefits including cultural responsiveness, patient comfort, and cost-effectiveness.[xcix] Promoting access to acute care outside of emergency room (ER) and hospital settings (as described in objective 20) can reduce costly ER visits. By providing the right type of care in outpatient settings, clinicians can help patients manage conditions that may otherwise worsen, become life-threatening and require hospital admissions.[c]

Health Equity: Preventable hospital admissions are associated with person-related factors including delayed health seeking, lack of knowledge of their health condition, stress levels, low income, and education, as well as system-related factors such as service capacity and lack of care continuity and coordination.[ci] Many of these factors impact the Medicaid-enrolled population. More equitable access to highly coordinated preventive care that prevents or slows disease progression can reduce avoidable hospitalizations.

Intervention(s): Several of the initiatives previously described, such as CDPAP and HCBS waivers (objectives 4 and 12), promotion of coordinated care through Health Homes and PCMH (objectives 2, 8, and 20), and reducing admissions via MAX (objective 20), aim to improve and

increase preventive care. These interventions ultimately improve the health and quality of life of Medicaid members, reducing the need for costlier downstream care.

Metric 21.1: Potentially Preventable Admissions			
Measure Description: Rate of hospital admissions per 1,000 enrolled members that could have potentially been preventable with better coordinated care, based on 3M methodology. **Source:** Medicaid Claims Data; 3M			
		Baseline Rate (2021) ***Rate per 1,000 members***	Target Rate
Statewide (Mainstream Medicaid Managed Care, HARP, HIV SNP, and Medicaid Fee-for-Service)		8.86	7.97
Age	0-20	5.18	
	21-44	5.92	
	45-64	20.13	
	65+	29.73	
Race	Asian/Pacific Islander	4.24	
	Black	15.74	
	Hispanic	8.74	
	White	8.91	
	Unknown	5.56	
	Other	16.77	
Sex	Male	10.03	
	Female	7.90	
Disability	Yes (Administrative Definition)	69.87	
	No (Administrative Definition)	6.49	

IX. Process for Quality Strategy Evaluation, Revision and Transparency

NYSDOH contracts with an EQRO to conduct mandatory and optional External Quality Review (EQR) activities as well as to annually evaluate the effectiveness of the QS. NYSDOH has determined that data and results from any Medicare or private accreditation reviews of an MCO are not a substitute for the quality improvement and measurement work that the NYSDOH and its EQRO perform with Medicaid and CHPlus managed care plans in NYS. Therefore, NYSDOH does not use information from any Medicare or private accreditation review of an MCO to provide information for the annual EQR.

To help NYS understand and address the effectiveness of the State's QS, and to determine whether any updates to the QS are necessary, the NYSDOH will continue to formally assess the QS objectives on an annual basis. The annual evaluation of the QS will be found in the Annual EQRO Technical Report and will include an assessment of the effectiveness of the interventions, which will include trending of indicator data, a review of validated PIP results and the results of the annual EQR. NYSDOH will use the information obtained from each of the EQR activities, as well as the information presented in the Annual EQRO Technical Report, to make modifications to the QS. The QS will be updated as needed, but no less than once every three years. The QS may be updated sooner if it is determined that significant change to the QS is needed, in which case the revised QS will be submitted to CMS. For purposes of reviewing and updating the QS, "significant change" is defined as:

- Legislative or regulatory changes resulting from State or federal amendments;
- changes to the structure or goals of the NYS Medicaid program that directly alter the intent, purpose, or scope of the QS; or
- results of the EQRO evaluation and a strong recommendation by the EQRO to modify the QS sooner than triennially.

Outside of the work of the EQRO, the NYS Medicaid/CHPlus program will also closely monitor progress on all QS metrics and intends to raise awareness about the Strategy within the NYSDOH through informal reports and presentations throughout each QS year.

Public Comments

Per CMS requirements, the QS is placed on the NYSDOH's website for 30 days prior to the QS being finalized to provide accountability, transparency, and garner support and guidance from consumers, professionals, advocates, and policy makers. In addition, NYS consulted with Tribes in NYS in accordance with the NYSDOH Tribal Consultation policy. Public comments and NYSDOH responses are posted here: https://www.health.ny.gov/health_care/medicaid/data_rpts/docs/2024-09-05_chpip_pub_com.pdf. A summary of comments received during the comment period are below.

NYSDOH received ten comments during the public comment period. Commenters included health plans, an Independent Provider Association, advocacy groups and associations, and measure stewards.

Several comments supported aspects of the Quality Strategy, including the use of Quality Incentive Program, the focus on race and ethnicity data completeness, measure alignment with CMS measure sets, and the focus on dental health and preventive health. Some comments recommended NYSDOH align with goals of existing waivers, and recommended against using proprietary “black box” measures in the Quality Strategy. Two comments suggested defining “sex” more clearly and other comments requested clarification on how primary care is defined. Some health plan commenters asked about populations included in specific metrics. Comments suggested additional measures: metrics on Medicaid churn, quality of non-emergency transportation service, improving additional demographic data completeness, quality of behavioral health services in outpatient settings, MLTC measures that do not rely on member recollection, and stratifying measures by gender identity and primary language. Some commenters flagged changes to measure names and definitions that may impact trending, and one commenter suggested integrating health plan accreditation to promote alignment across plans. Additionally, several comments flagged important issues the NYSDOH should review and work to address, including: promoting integrated care, primary care workforce and support for primary care generally, hybrid payment models, eligibility thresholds for home services, and changes to Consumer Directed Personal Assistance. These comments were referred to relevant parties within the NYSDOH.

NYSDOH reviewed all comments and made the following updates to the Quality Strategy as a result: “sex” is now clarified as “sex assigned at birth”; the baseline year for metric 9.1 has been updated to 2022 to allow for ongoing trending because the measure definition changed between 2021 and 2022; several measures (9.1, 9.2, 11.1, 14.1, 14.2, 15.3, 20.1) included a baseline and target rate tied to a population subset that included only mainstream managed care and CHPlus—we have revised those metrics to establish one statewide baseline and target rates that includes additional plan types; objective 14 was updated to include information on NYSDOH’s proposed changes continuous enrollment for children; a note was added to metric 15.2 to document the measure name change that occurred in 2024; and metric 21.1 was re-run to omit dual enrollees and MLTC members because of claim incompleteness. All comments will be saved and reviewed during the preparation of the 2026-2028 Quality Strategy.

The current QS can be found on the NYSDOH’s public website at: https://www.health.ny.gov/health_care/medicaid/data_rpts/quality_strategy.htm

The NYSDOH will publish the annual technical report at Annual External Quality Review Technical Report - New York State Department of Health (ny.gov). The publication will allow all interested parties to see the progress being made across the quality measures included in the QS

Appendix 1

Metric Name	Metric Source	Population	Baseline Year	Baseline Result	Target	Methodology for Target
1.1 Reduce the number of uninsured	American Community Survey	Statewide population age 0 to 64	2021	9%	8%	Improvement of 10% (baseline x 1.1)
2.1 Getting Care Quickly (CAHPS)	CAHPS	Adult Survey: Medicaid Managed Care and HIV SNP (age 18+), HARP (age 21+) Child Survey: Medicaid Managed Care and HIV SNP (age 0-17) and CHPlus members	2020 (child); 2021 (adult)	88% (child) 79% (adult)	91% (child) 85% (adult)	10% x (90th percentile – baseline)
3.1 Proportion of total population in MAP, PACE and Partial in a MAP or PACE	NYS Medicaid Enrollment Data	Medicaid managed long term care plan members	2022	14%	15%	Improvement of 10% (baseline x 1.1)
4.1 Quality of Home Health Aide/Personal Care Aide	MLTC Satisfaction Survey	Medicaid managed long term care plan members (sample)	2021	91%	95%	10% x (90th percentile – baseline)
5.1 Social Need Screening and Intervention	QARR	Mainstream Medicaid managed care, HARP, and HIV SNP members	2023	TBD—New Measure	20%	Based on DOH 1115 Waiver goal
6.1 No Falls Injury	Community Health Assessment	MAP, PACE, and Partial MLTC plans; members aged 18 and older	2022	90%	91%	10% x (90th percentile – baseline)
7.1 Medicaid Enrolled Dentists	NYS Licensure Data; Medicaid Claims Data	NYS Licensed Dentists	2022	42%	46%	Improvement of 10% (baseline x 1.1)
8.1 Proportion of members in a PCMH	NCQA PCMH Data; Medicaid Panel/Roster Data	Mainstream Medicaid Managed Care, HARP, HIV SNP members	2022	66%	67.5%	Based on DOH goal to increase penetration by 0.5% each year.
9.1 Follow-Up After Emergency Department Visit for Substance Use - 7 & 30 day	QARR	Mainstream Medicaid managed care, HARP, HIV SNP, and CHPlus members	2022	32% (7-day) 44% (30-day)	33% (7-day) 46% (30-day)	10% x (90th percentile – baseline)
9.2 Follow-Up After Emergency Department Visit for Mental Illness - 7 & 30 day	QARR	Mainstream Medicaid managed care, HARP, HIV SNP, and CHPlus members	2021	52% (7-day) 67% (30-day)	54% (7-day) 69% (30-day)	10% x (90th percentile – baseline)
10.1 Topical Fluoride for Children	QARR	Mainstream Medicaid Managed Care, HIV SNP, and CHPlus members aged 1 to 20	2023	TBD--New Measure	To be calculated after first reporting period	10% x (90th percentile – baseline)
10.2 Annual Dental Visit (PIP Measure--Adults)	Medicaid Claims Data	Mainstream Managed Care, HARP, HIV SNP, and Medicaid Fee-For-Service members aged 21 to 64	2021	20%	22%	Improvement of 10% (baseline x 1.1)
11.1 Postpartum Care	QARR	Mainstream Medicaid managed care, HARP, HIV SNP, and CHPlus members	2021	81%	82%	10% x (90th percentile – baseline) +1% if equal to baseline
12.1 Members in 1915c programs with Physical Exam	Waiver Participant Roster, Medicaid Claims Data	Children's Waiver Participants (sample)	2022-2023	56%	85%	85% represents a CMS-determined passing rate
13.1 Proportion of members who utilize primary care	Medicaid Claims Data; Medicaid Enrollment Data	Mainstream Medicaid Managed Care, HARP, HIV SNP, MLTC, and Fee-for-Service Medicaid members	2022	66%	73%	Improvement of 10% (baseline x 1.1)
14.1 Well-Child Visits in the First 30 Months of Life	QARR	Mainstream Medicaid managed care, HIV SNP, and CHPlus members aged 0 to 30 months	2021	72%	73%	10% x (90th percentile – baseline)
14.2 Child and Adolescent Well-Care Visits	QARR	Mainstream Medicaid managed care, HIV	2021	70%	71%	10% x (90th percentile – baseline)

		SNP, and CHPlus members age 3 to 21				
14.3 Follow-Up Care for Children Prescribed ADHD Medication	QARR	Mainstream Medicaid Managed Care, HIV SNP, and CHPlus members age 6 to 12	2021	53% (initiation); 62% (continuation)	55% (initiation); 63% (continuation)	10% x (90th percentile – baseline)
15.1 Viral Load Suppression	QARR	Mainstream Medicaid Managed Care and CHPlus members	2021	73%	75%	10% x (90th percentile – baseline)
15.2 Hemoglobin A1c Control for Patients with Diabetes (Glycemic Status Assessment for Patients With Diabetes)	QARR	Mainstream Medicaid Managed Care, HARP, and HIV SNP members age 18 to 75	2021	55%	57%	10% x (90th percentile – baseline)
15.3 Asthma Medication Ratio – Both Adult and Child (5-64)	QARR	Mainstream Medicaid managed care, HARP, HIV SNP, and CHPlus members age 5 to 64	2021	55%	56%	10% x (90th percentile – baseline)
16.1 Colorectal Cancer Screening	QARR	Mainstream Medicaid Managed Care, HARP, and HIV SNP members age 45 to 75	2021	61%	62%	10% x (90th percentile – baseline)
16.2 Childhood Immunization Status (Combo 10)	QARR	Mainstream Medicaid Managed Care, HIV SNP and CHPlus members age 2	2021	42%	43%	10% x (90th percentile – baseline)
17.1 Hep C Elimination Measure -- Universal screening for pregnant people	Medicaid Claims Data	Pregnant Mainstream Medicaid Managed Care, HARP, HIV SNP, and Fee-for-Service members (all ages)	2022	72%	79%	Improvement of 10% (baseline x 1.1)
18.1 Completeness of Race/Ethnicity Data	Medicaid Enrollment Data	Medicaid members (all ages) (managed care + FFS)	2022	74%	81%	Improvement of 10% (baseline x 1.1)
19.1 Pharmacotherapy for Opioid Use Disorder	QARR	Mainstream Medicaid Managed Care, HARP, HIV SNP, and CHPlus members age 16+	2021	32%	33%	10% x (90th percentile – baseline)
20.1 Follow-Up After Hospitalization for Mental Illness - 7 & 30 day	QARR	Mainstream Medicaid managed care, HARP, HIV SNP, and CHPlus members age 6+	2021	63% (7-day) 79% (30-day)	64% (7-day) 80% (30-day)	10% x (90th percentile – baseline)
21.1 Potentially Preventable Admissions	3M	Mainstream Medicaid Managed Care, HARP, HIV SNP, and Medicaid Fee-for-Service	2021	8.86 per 1,000 members	7.97 per 1,000 members	Improvement of 10% (baseline x 0.9)

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