

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

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

**The Blueprint for a Healthier State**

**Table of Contents**

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<b>Introduction</b> .....	<b>2</b>
<b>Medicaid and CHPlus Managed Care in New York State</b> .....	<b>2</b>
<b>The Quality Strategy Purpose</b> .....	<b>6</b>
<b>Process for Quality Strategy Development</b> .....	<b>6</b>
<b>The Quality Strategy Blueprint</b> .....	<b>7</b>
<b>Measurement and Assessment of Managed Care Organizations</b> .....	<b>11</b>
<b>Measurement and Assessment of the Quality Strategy</b> .....	<b>15</b>
<b>Quality Strategy Goals and Interventions</b> .....	<b>16</b>
<b>AIM 1: Improved Population Health</b> .....	<b>16</b>
<b>Goal 1: Improve Maternal Health</b> .....	<b>17</b>
<b>Goal 2: Ensure a Healthy Start</b> .....	<b>19</b>
<b>Goal 3: Promote Effective and Comprehensive Prevention and Management of Chronic Disease</b> .....	<b>22</b>
<b>Goal 4: Promote the Integration of Suicide Prevention in Health and Behavioral Healthcare Settings</b> .....	<b>33</b>
<b>Goal 5: Prevent and Reduce Nicotine, Alcohol, and Substance Use Disorder</b> .....	<b>35</b>
<b>AIM 2: Improved Quality of Care</b> .....	<b>41</b>
<b>Goal 6: Improve Quality of Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) Treatment</b> .....	<b>42</b>
<b>Goal 7: Promote Prevention with Access to High Quality Care</b> .....	<b>43</b>
<b>Goal 8: Support Members in Their Communities</b> .....	<b>50</b>
<b>Goal 9: Improve Patient Safety</b> .....	<b>56</b>
<b>AIM 3: Lower Per Capita Cost</b> .....	<b>60</b>
<b>Goal 10: Pay for High Value Care</b> .....	<b>61</b>
<b>Process for Quality Strategy Evaluation, Revision and Transparency</b> .....	<b>65</b>
<b>Appendix 1</b> .....	<b>67</b>

## Introduction

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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 achieve the triple aim of: Improved Population Health, Improved Quality of Care, and Lower Per Capita Cost while reducing health disparities.

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

The QS, a requirement of 42 CFR § 438.340 and 42 CFR § 457.1240(e), identifies the goals of the Medicaid/CHIP program and the actions taken by the 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, as the current version employs a new goal-based format to identify and prioritize the areas in which quality improvement is most needed and most attainable. To that end, ten priority goals have been identified to drive improvement in the Medicaid and CHPlus programs and align with the triple aim.

## Medicaid and Child Health Plus Managed Care in New York State

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Effective care management and care coordination are critical lynchpins that support New York State (NYS) meeting the goals laid out in the QS. NYS supports a vision that the majority of Medicaid members will eventually be enrolled in Managed Care. All children enrolled in New York's Children's Health Insurance Program (CHIP), Child Health Plus, are also enrolled in managed care with the same health plans participating in the Medicaid managed care program. 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.

NYS's Medicaid Managed Care (MMC) program 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 health care 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 living with HIV/AIDS, and their children. HIV SNPs are required to have a network of experienced HIV service providers, HIV specialist 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.
- HARPs manage an enhanced benefit package of behavioral health home and community-based services (BH HCBS) and Community Oriented Recovery and Empowerment (CORE) services.
- HARPs 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 a person 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 a MLTC plan may be mandatory or voluntary, depending on individual circumstances.

The Child Health Plus Program (CHPlus) serves the healthcare needs of children under the age of 19 that are uninsured and 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 abuse, dental, vision and emergency care.

Regardless of plan type, NYS Medicaid and CHPlus MCOs ensure comprehensive health care 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 the American Academy of Pediatrics, the American Academy of Family Physicians, the American Psychiatric Association, the US Preventive Services Task Force, the New York State Child/Teen Health Program (C/THP) standards for provision of care to individuals under age twenty-one years, the American Medical Association's Guidelines for Adolescent and Preventive Services, the US Department of Health and Human Services Center for Substance Abuse Treatment, New York State OASAS clinical standards, American Society of Addiction Medicine (ASAM), US Substance Abuse and Mental Health Services Administration (SAMHSA), the American College of Obstetricians and Gynecologists, the American Diabetes Association, the 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 the 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(b)(3) and 42 CFR 457.1216.

NYS Medicaid transition of care policy requires that:

- In instances in which an enrollee newly transitions into a Medicaid managed care health plan (either from FFS or another Medicaid managed care health plan or coverage type):
  - When 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 60 days after delivery.
- In instances in which a provider leaves a Medicaid 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 60 days after delivery.

NYSDOH monitors the MCO's network of providers, professionals, and hospitals to ensure adequacy per contract standards. The link to the Medicaid Managed Care Model Contract is:

[Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan Model Contract \(ny.gov\)](#).

When establishing the network of providers, the MCO must consider anticipated enrollment, expected utilization of services by the population to be enrolled, 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, and the geographic location of the providers and enrollees. In addition, the MCO's network must contain all the provider types necessary to furnish the benefit package, including providers of long-term supports and services for individuals enrolled in an MLTC MCO.

The Medicaid Managed Care Model Contract also addresses each piece of the availability of service standards, as required in 42 CFR 438.206. Section 21, Section 10.10, 10.15, and 10.16 of the Medicaid Managed Care Model Contract include requirements for managed care plans as it relates to their provider network, direct access to women's health specialists, medical and surgical second opinions, out of network care, credentialing, and coverage of family planning services. Timely access to care is covered in the Medicaid Managed Care Model Contract in Sections 21.1 and Sections 15.1, 15.2, 15.3, and 15.4. The Medicaid Managed Care Model Contract requires MCOs to deliver care in a culturally competent manner through access and cultural considerations covered in Sections 15.10, 15.11, 12.2, 12.3, and 13.2. MCOs must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. Accessibility considerations are covered in the Medicaid Managed Care Model Contract Sections 15.5, and Section 24.

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 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 managed care program.
- Discriminating among enrollees on the basis of their health status or need for health care services.
- Misrepresenting or falsifying information that a health plan furnishes to an enrollee, potential enrollee, health care provider, NYS, or to 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 may include but are not limited to:

- Civil monetary penalties pursuant to 18 NYCRR Part 516 and 42 CFR Part 438, subpart I, and such other sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program or to the delivery of the contracted for services.
- Suspension of all new enrollment, including auto assignments, after the effective date of the sanction.
- Termination of the contract with NYS, pursuant to Section 2.7 of the New York State Medicaid Model Contract which outlines terms for termination of the agreement.
- Temporary management, pursuant to 42 CFR 438.702, 42 CFR 438.706 and 18 NYCRR 360-10.11(e).

All Medicaid 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).

## The Quality Strategy Purpose

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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 and CMS's Triple Aim;
- 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;
- Identify opportunities for improvement in health outcomes for New Yorkers enrolled in Medicaid Managed Care and CHPlus through comprehensive preventive health services, management of chronic diseases, and substance use and mental health services; and
- Identify new and creative models of care delivery based on evidence-based practices to reduce the cost for individuals, families, and the state of New York.

## Process for Quality Strategy Development

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The NYSDOH utilizes a multidisciplinary approach to developing, evaluating, and revising the QS. This approach involves multiple stakeholders, including the public, providers, MCOs,

advocates, external partners, and special populations. Stakeholders are invited to review and comment on the goals and quality metrics outlined within the QS. 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. The final QS is subject to, and dependent on, CMS approval. Following an extensive review of NYS Medicaid Program activities, evaluation of utilization and performance data, and collaboration with partners in the NYS OMH, Office of Children and Family Services (OCFS), and OASAS, the document known as the "Blueprint" was developed.

## Quality Strategy Blueprint

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The NYSDOH has re-envisioned its QS to focus on 1) achieving measurable improvement among ten priority goals outlined in Table A, "*The Blueprint*," and 2) reducing health disparities. The Triple Aim, first articulated by the Institute for Healthcare Improvement, was chosen as the organizational framework by which the goals of the QS are organized. The Aims of: (1) Improved Population Health, (2) Improved Quality of Care, and (3) Lower Per Capita Costs frame the roadmap to optimize the healthcare delivered by the NYS Medicaid and CHPlus Programs. Each of the ten goals of the QS has one or more measures that will be used to assess progress towards that goal. Each measure was carefully selected to align with the overarching goal and identified by subject matter experts as high value and high impact. The measures were selected from the NYS Quality Assurance Reporting Requirements (QARR) Measurement Set, the Centers for Disease Prevention and Control's (CDC's) Youth Risk Behavior Surveillance System (YRBSS), the CDC's Behavioral Risk Factor Surveillance System (BRFSS), the National Survey on Drug Use and Health (NSDUH), 3M's Potentially Preventable Admissions (PPA), CMS's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) annual participation report, and other NYS specific measures. Measures that are from the QARR measurement set are only applicable to the Managed care population. BRFSS measures include both managed care and fee-for-service populations. For other measures such as the 3M PPA and the YRBSS measures, the applicable population is identified in the text of the QS. 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 managed care population. The NYSDOH has chosen to highlight within this report some, not all, of the public health interventions that are currently utilized to drive quality improvement towards the identified goals.

An overarching tenet of the QS and the NYSDOH is reducing health disparities to achieve health equity. 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 health care."<sup>1</sup> In order to achieve this goal, the NYSDOH recognizes that it must increase the



assessment and consideration of the various social determinants of health (SDH) that affect Medicaid and CHPlus members and promote cultural competency (CC). The NYS Medicaid Program created the Bureau of Social Determinants of Health to identify and address the policies, systems, economic, and social factors that affect the lives of NYS Medicaid members. Additionally, NYSDOH was the first state in the nation to require that Medicaid risk-based value-based payment arrangements include SDH interventions and contracting with one or more community-based organizations (CBOs). NYSDOH is committed to the development of interventions to improve the quality of health care while also reducing health disparities. All interventions listed in the QS aim to reduce disparities. In this QS there was an effort to demonstrate NYSDOH investment in this endeavor, by including a tag beside the title of each intervention in the QS indicating whether the intervention addresses one or both core elements for the reduction of disparities: SDH and/or CC.

**Social Determinants of Health (SDH):** SDH includes non-medical factors such as employment, income, housing, transportation, childcare, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.

**Cultural Competency (CC):** The Commonwealth Fund defines cultural competence in health care as, "...the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."<sup>2</sup>

Table A displays the Blueprint in a summary visual format cross-walking The Triple Aim to the ten goals and the interventions being implemented to achieve each goal. In the final column, an indicator has been added to assist readers in understanding which Core Elements for the Reduction of Disparities (CC and/or SDH) have been integrated into each intervention.

**Table A: The New York State Medicaid Quality Strategy: The Blueprint for a Healthier State, 2021**

Triple Aim	Goals	Programmatic /System-wide Interventions	Intervention Integrates Elements of Cultural Competency (CC) or Social Determinants of Health (SDH)	
			CC	SDH
Improved Population Health	<b>A1:G1:</b> Improve Maternal Health	Improve Maternal Health and Reduce Maternal Mortality	✓	✓
	<b>A1:G2:</b> Ensure a Healthy Start	First 1000 Days on Medicaid: Bridging Education with Health Sectors	✓	✓
		Optimize the Developmental Trajectory: The 2019-2021 Kids Quality Agenda Performance Improvement Project (PIP)	✓	✓
		Pediatric Dental Care in Primary Care		
	<b>A1:G3:</b> Promote Effective and Comprehensive Prevention and Management of Chronic Disease	NYS Medicaid National Diabetes Prevention Program	✓	✓
		Behavioral Health Integration	✓	
		<b>Promote Health Management for All</b>		
		<ul style="list-style-type: none"> <li>• <i>Improving Asthma Control to Reduce Avoidable Asthma Emergency Department Visits and Hospitalizations</i></li> <li>• <i>Controlling High Blood Pressure</i></li> </ul>	✓	✓
		<b>Care Management for All</b>	✓	✓
		<ul style="list-style-type: none"> <li>• <i>Adult Health Homes</i></li> <li>• <i>Transitioning the Foster Care Population into MMC</i></li> <li>• <i>Usage of Care Coordination, Provider Supports in Value Based Payment</i></li> </ul>		

Triple Aim	Goals	Programmatic /System-wide Interventions	Intervention Integrates Elements of Cultural Competency (CC) or Social Determinants of Health (SDH)	
			CC	SDH
	<b>A1:G4:</b> Promote the Integration of Suicide Prevention in Health and Behavioral Healthcare Settings	The Zero Suicide Model	✓	✓
	<b>A1:G5:</b> Prevent and Reduce Nicotine, Alcohol, and Substance Use Disorder	Provide a Comprehensive Smoking Cessation Benefit	✓	✓
		The New York State Smokers' Quitline	✓	✓
		Mass-Reach Health Communications	✓	
		Alcohol and Substance Use, Misuse, and Disorder	✓	✓
		Combating the Opioid Epidemic	✓	✓
<b>Improved Quality of Care</b>	<b>A2:G6:</b> Improve Quality of Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) Treatment	Learning Collaboratives, Regulatory Changes, and Peer Linkages	✓	✓
		Expansion of Take-home Methadone Dosing	✓	✓
	<b>A2:G7:</b> Promote Prevention with Access to High Quality Care	Patient-Centered Medical Home	✓	✓
		Maximize Workforce Distribution		
		Provider Wellness Survey		
		Community Health Workers	✓	
		Network Adequacy		
After-hours Care				
Telehealth and Remote Patient Monitoring Innovations				

Triple Aim	Goals	Programmatic /System-wide Interventions	Intervention Integrates Elements of Cultural Competency (CC) or Social Determinants of Health (SDH)		
			CC	SDH	
		Provide Safe, Reliable Transportation		✓	
		Performance Improvement Projects	✓		
		Focus Clinical Studies			
	<b>A2:G8:</b> Support Members in Their Communities	Support Palliative Care Models	✓		
		Home and Community-Based Services (HCBS)	✓	✓	
	<b>A2:G9:</b> Improve Patient Safety	Appropriate Antibiotic Use in Outpatient Healthcare			
		Reducing Sepsis			
		Breast Cancer Selective Contracting			
	<b>Lower Per Capita Cost</b>	<b>A3:G10:</b> Pay for High-Value Care	Medicaid Reform and the Move to Value-based Payments	✓	✓
			Value-based Payment Core Measurement Strategy		
Promote Data Sharing via the Health Information Exchanges and the Statewide Health Information Network for New York (SHIN-NY)					
Reduce Avoidable Hospital Use			✓		

## Measurement and Assessment of Medicaid and CHPlus Managed Care Organizations

The 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.

To ensure the accuracy, integrity, reliability, and validity of the data submitted, the NYSDOH contracts with an External Quality Review Organization (EQRO). The EQRO audits data submissions and provides technical assistance to MCOs in collecting and submitting requested information.

### 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 Quality and Patient Safety (OQPS) 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**

		Percentile		
		0 < 50%	50% < 90%	90% - 100%
Trend	↑	<b>C</b>	<b>B</b>	<b>A</b>
	0	<b>D</b>	<b>C</b>	<b>B</b>
	↓	<b>F</b>	<b>D</b>	<b>C</b>

- A** Performance is notable. No action plan required
- B, C** No action plan required
- D, F** Root cause analysis and action plan required

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 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 every other year.

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 health care needs of mainstream MMC, CHPlus, MLTC, HARP and HIV SNP populations. At the state level, QARR measures are used in many state initiatives including the NYS 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/](https://www.health.ny.gov/health_care/managed_care/reports/)) and Health Data New York.

### Encounter Data Collected through the Encounter Intake System (EIS)

All Medicaid and CHPlus MCOs are required to submit monthly encounter data to the Department. The EIS collects data consistent with national standards for a national uniform core data set. Encounter data provide 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.

### 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 health care 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 implementing the UAS-NY to identify persons who need home and community-based LTSS in New York. The UAS-NY is administered by a registered nurse from the Conflict-Free Evaluation and Enrollment Center (CFEEC). CFEEC is a New York State Medicaid program that determines a person's eligibility for LTSS. It is run by Maximus, a contractor of the New York State Medicaid program. CFEEC is not affiliated with any managed care plan, or with any provider of health care or long-term care services. Any Medicaid eligible individual needing LTSS is welcomed to call the CFEEC-Maximus evaluation and enrollment center to schedule an evaluation for LTSS. A doctor's referral is not needed. The UAS-NY system establishes a single, unique functional record for all enrollees of NYS Medicaid's home and community-based long-term care network, further enabling comprehensive assessments. Additionally, the UAS-NY facilitates access to programs and services, eliminates duplicative assessment data, and improves consistency in the assessment process. The UAS-NY system also contains the interRAI Community Mental Health Assessment, which is used to determine HCBS eligibility and HCBS plans of care for HARP members and HARP-eligible individuals enrolled in HIV SNPs.

### 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 New York State of Health (NYSoH), 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.

## Measurement and Assessment of the Quality Strategy

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As previously noted, NYSDOH has identified ten priority goals for the QS which are more thoroughly discussed in the 'Quality Strategy Goals and Interventions' section of this report. To measure progress towards each goal, NYS has identified quality 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. Disability is determined by performing a step-by-step evaluation of a client's impairments and their ability/inability to perform work. Medical evidence is reviewed and used to determine if the client's condition meets the definition of disability, using a sequential evaluation process based on Social Security Administration (SSA) criteria. Children who qualify for Medicaid based on disability status are not eligible for CHPlus.

To evaluate progress in their reduction, there is a need to measure health disparities. To this end, the following QARR measurement set quality measures have been stratified by enrollee demographics, including age, sex, race/ethnicity, and Supplemental Security Income (SSI) status, and included in the QS:

- Postpartum Care
- Asthma Medication Ratio (Age 5-18 and Age 19-64)
- Follow-up After Emergency Department Visit for Mental Illness 30-Days (FUM)

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 members 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 members sex defined as Male or Female.
- **Supplemental Security Income (SSI)** is a federal program whose members are aged, blind, or disabled. Individuals eligible for SSI receive cash assistance.

Visualizations of the stratified rates are presented in the “Spotlight on Disparities” sections under the applicable goal. Stratified measures will be updated annually to evaluate the effectiveness of NYS’s Medicaid and CHPlus programs in addressing and mitigating observed disparities.

Each metric that is included in the QS has a baseline rate using 2019 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 90<sup>th</sup> percentile of all Medicaid managed care plan performance. For example, if the baseline rate was 72 percent, and the 90<sup>th</sup> 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  $1.4\% = 10\% \times (86\% - 72\%)$ . 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.

## Quality Strategy Goals and Interventions

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### AIM 1: Improved Population Health

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NYS is committed to ensuring that every Medicaid and CHPlus member has access to high-quality, cost-effective health care that is effectively managed. Medicaid reform in NYS is focused on improving population health. NYS seeks to use the Medicaid and CHPlus programs to support and drive lasting improvement in the provision of health care across all payers for all New Yorkers.

NYS Medicaid, covering more than 6 million residents, nearly one third of the state’s population, has a vested interest in addressing preventable conditions and promoting health. While Medicaid has traditionally been viewed as an insurer of low-income and vulnerable populations, the program’s coverage of essential public health services and financing of public hospitals and clinics affects health status and outcomes statewide.

NYS has long demonstrated its commitment to health equity 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 more than 385,000 children in NYS. The NYSDOH is committed to performing a variety of quality improvement and outreach activities in order to decrease the number of children in NYS that do not have access to health insurance and address preventable conditions.

**Goal 1: Improve Maternal Health**

In 2019, NYS ranked 23rd in the nation for its maternal mortality rate with clear racial disparities.<sup>5</sup> According to data from 2015-2017, Black women in NYS are over three times more likely to die in childbirth than White women (48.4 vs. 14.7 maternal deaths per 100,000 live births, respectively).<sup>6</sup> The NYS Maternal Mortality Review Initiative found that in the 2014 cohort:<sup>4</sup>

- The top five causes of pregnancy-related deaths were infection (21.2%), hemorrhage (15.2%), cardiomyopathy (12.1%), embolism (12.1%) and pulmonary problems (12.1%). Sixty-seven percent of the pregnancy-related deaths occurred within a week of the end of pregnancy.
- The top causes of pregnancy-associated, but not related deaths, were injury (55.0%), cancer (10.0%), neurologic/neurovascular problems (6.7%), and pulmonary problems (6.7%). Of the deaths caused by injuries, substance overdose (36.4%) and motor vehicle accident (27.3%) were the top reported injuries.

NYS has launched a comprehensive initiative to target maternal mortality and reduce racial disparities in health outcomes. The multi-pronged initiative includes efforts to review and better address maternal death and morbidity with a focus on racial disparities, improving access to prenatal and perinatal care, and expanding community outreach.

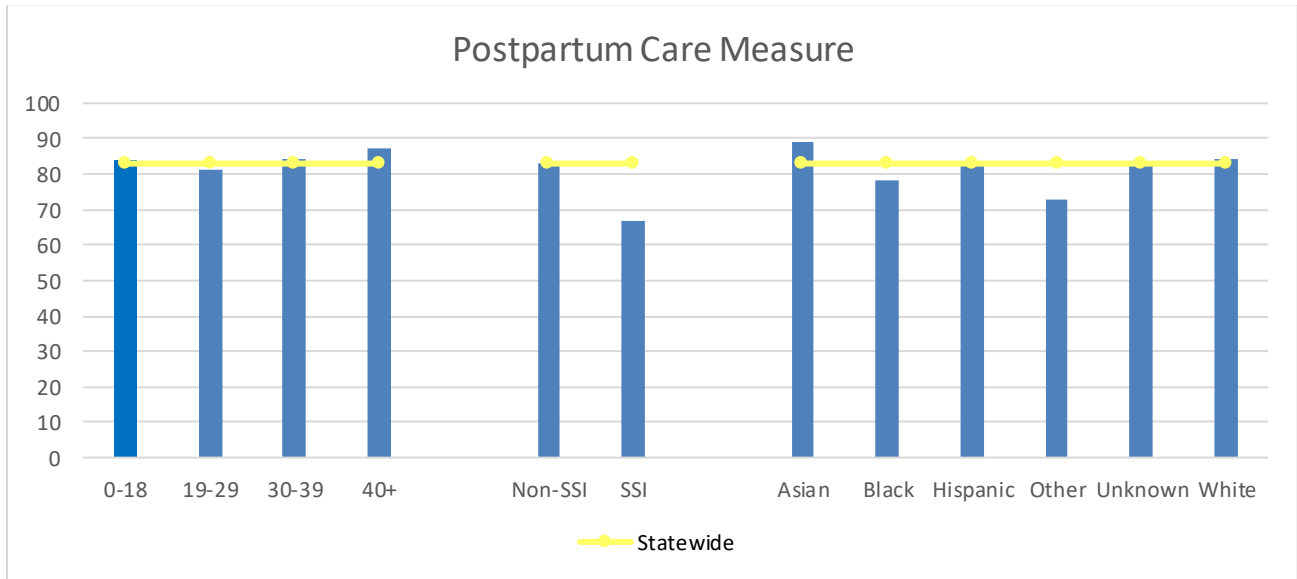
**Table 1:** Metrics, Baseline Rates, and Target Rates for *Improve Maternal Health (A1:G1)*

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#1: Postpartum Care (PPC)	83%	84%
#2: Maternal Mortality Rate in NYS	18.9 per 100,000 live births (2015-17)	16 per 100,000 live births (2024)

**Spotlight on Disparities: Postpartum Care**

Variation was observed in the 2019 Postpartum Care measure (Figure 1). Populations with rates below the statewide average of 83% included Black women (78%), recipients of SSI (67%) and enrollees age 19-29 (81%).

**Figure 1: 2019 Postpartum Care Stratified by Enrollee Demographics**



**Interventions:**

**Improve Maternal Health and Reduce Maternal Mortality (CC, SDH)**

NYSDOH has multiple ongoing efforts to address maternal morbidity and mortality and reduce racial disparities including:

- Convening the Maternal Mortality Review Board, whose members are charged with reviewing the cause of each maternal death in NYS and making recommendations to the NYSDOH on strategies for preventing future deaths and improving overall health outcomes;
  - Additionally, convening the NYS Maternal Mortality Advisory Council, comprised of perinatal experts and community members from across NYS. The Advisory Council is charged with working in collaboration with the Review Board to develop recommendations aimed at improving maternal health outcomes across the State;
- Conducting an administrative and medical record analysis of NYS MMC and FFS members who were diagnosed with maternal sepsis to inform strategies to reduce maternal mortality and morbidity. The analysis will evaluate the characteristics, identification, and management of sepsis associated with pregnancy, delivery, postpartum, and post-abortion obstetrical states. Results will be used to identify women at risk for maternal sepsis and modifiable factors associated with maternal sepsis morbidity and mortality;
- Launching a NYS Birth Equity Improvement Project, aimed at addressing bias, racism, and disparities impacting maternal health through a birthing facility-based learning collaborative;
- Leading the NYS Perinatal Quality Collaborative (PQC) to reduce pregnancy complications, improve maternal and neonatal outcomes, and reduce racial/ethnic and geographic disparities;

- Additionally, working to expand participation of birthing centers, including midwifery birth centers (MBCs), in the PQC;
- Establishing a perinatal data module to support access to perinatal outcome data through the State’s All Payer Database;
- Prioritizing the public health focus of the NYS regional perinatal system through adoption of updated regulations that strengthen the role of regional perinatal centers, increase focus on obstetrical care, and incorporate birthing centers and MBCs into the system;
- Increasing the number of MBCs statewide as a first level of care for low-risk pregnancies;
- Updating standards for Medicaid providers who provide maternity care and working with MMC plans to ensure adherence to those standards;
- Evaluating potential strategies for expanding access to childbirth education classes for pregnant individuals;
- Supporting the expansion of perinatal telehealth access, with a focus on rural hospitals and health care providers;
- Working to implement the recommendations of the NYS Postpartum Workgroup to optimize postpartum care in the State;
- Ensuring postpartum home visits are available to all individuals on Medicaid who agree to have them;
- Working with maternal/perinatal infant community health collaboratives to expand and enhance community health worker services to address key barriers that impact maternal outcomes; and
- Supporting a perinatal mood, anxiety, and depression education campaign.

### Goal 2: Ensure a Healthy Start

The NYSDOH recognizes that the first year of a child’s life has long-range effects on health and well-being. Optimal growth and development in early childhood have been scientifically proven to have sustained impacts on health, educational achievement, and economic productivity. Many children are at risk for not achieving their full potential due to individual and community-based disparities in health and available services. Two critical foci in early childhood development have been the First 1,000 Days on Medicaid Initiative, which was implemented to shift the definition of health from the absence of disease to the well-being of an individual, and the promotion of pediatric engagement in children’s oral health.

**Table 2:** Metrics, Baseline Rates and Target Rates for *Ensure a Healthy Start (A1:G2)*

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#3: Lead Screening in Children	89%	90%
#4: Percent of Total Members Receiving Oral Health Services provided by a Non-Dentist Provider	0.8%	1.6%

## **Interventions**

### **Optimize the Developmental Trajectory: The 2019-2021 Kids Quality Agenda PIP (CC, SDH)**

The first three years of a child's life are a time of rapid development. It is critical during this time to mitigate risks to a healthy developmental trajectory, such as lead exposure and hearing loss, and ensure early identification and intervention for developmental delay. Ensuring timely identification and services for children at risk have long-term impacts over the life course. Data have shown that there is opportunity for improvement in NYS to identify children at risk for developmental delay and ensure that they receive appropriate services to minimize risk.

The 2019-2021 Kids Quality Agenda PIP incorporates three focus areas: (1) blood lead testing and follow-up; (2) newborn hearing screening and follow-up; and (3) developmental screening. Blood lead testing, the first focus area, is required by CMS for all children enrolled in Medicaid. Children are to receive blood lead testing at ages 12 months and 24 months per this requirement. In addition, NYS law mandates that all children receive blood lead level tests twice prior to turning 3 years old, once around age one and again around age two. The second focus area is the required newborn hearing screening. Based on the NYSDOH Early Hearing and Detection and Intervention Program data for 2016 and 2017, there is a need for improvement in follow-up of infants who do not pass their newborn hearing screening. Infants who have not passed at least one hearing screening are at a higher risk of having hearing loss. It is important that infants who do not pass their hearing screening have follow-up evaluation by three months of age. Research supports the need for early intervention services by 6 months of age for infants to achieve language development on par with peers their same age. Early diagnosis is integral to mitigating language deficits. Children diagnosed with permanent hearing loss who receive intervention services by ages 3-6 months experience significantly better language development than such children who do not receive intervention services. The third focus area is developmental screening. Developmental disabilities or disorders are a diverse group of conditions with mental, behavioral, and/or physical impairments that can profoundly affect different areas of a child's life such as language, mobility, learning, self-help, and independent living. Early identification of children with delayed or disordered development, i.e., children who are not developing according to expected trajectories, is critical to ensure timely, appropriate intervention. The American Academy of Pediatrics (AAP) recommends developmental surveillance at every well-child visit and periodic administration of standardized developmental screening tests to ensure timely identification of children at risk for developmental, behavioral, and social delays. Surveillance is the process of recognizing children who may be at risk of developmental delays. In contrast, developmental screening is a more structured process that involves the use of one or more standardized, validated screening tools to identify and refine the recognized risk. The AAP recommends that developmental screening be performed with a multi-domain screening tool at well-child visits at ages 9 months, 18 months, and 30 months and that developmental surveillance be performed at all other well-child visits. In addition to the AAP recommendation, developmental screenings are required for children enrolled in Medicaid under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). In addition to formal global developmental screening, the AAP also recommends screening with an autism-specific tool during the 18- and 24-month visits.

## **Pediatric Dental Care in Primary Care**

The 2018 Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Participation Report (form CMS-416) reveals a significant underutilization of dental services among infants and children. Tooth decay is the most common chronic, preventable, childhood disease, surpassing asthma, early-onset obesity, and diabetes.<sup>7</sup> Poor oral health can severely affect the health and well-being of an infant or child. The American Dental Association and American Academy of Pediatric Dentists recommend children see their dentist by age one.<sup>8</sup> Health professionals play an important role in the promotion of oral health. In the Child Core Set report for Federal Fiscal Year (FFY) 2017, approximately 59 percent of children had six or more well-child visits in the first fifteen months of life.<sup>9</sup> By contrast, according to the 2017 Center for Medicare and Medicaid Services (CMS) 416 report, only about 5 percent of children up to one year of age had any dental service.<sup>10</sup> Fluoride varnish application to the primary dentition can reduce caries incidence.<sup>11</sup> Evidence supports the use of fluoride varnish up to four times a year to decrease the caries rate in high-risk infants and children.<sup>12</sup> Application of fluoride varnish in a primary care setting is a way to intercept early childhood caries sooner and allow for early referral to a dental home. In 2009, Medicaid and CHPlus created a policy that would allow a non-dentist provider to apply fluoride varnish in the primary care setting. This is the only dental service that a non-dentist provider can perform under the NYS Dental Medicaid Program.

Fluoride Varnish application by a Non-Dentist Provider is being evaluated through the Annual EPSDT report (form CMS- 416), which is publicly available. The measure, *Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider*, has been in use since 2010. The QS target for this metric is to increase fluoride varnish application by 10 percent in primary care settings by non-dentist providers over the next three years. The NYSDOH continues to promote the use of fluoride varnish in the primary care setting. The NYSDOH's Division of Family Health is in the process of developing tools and resources for training at the local level through an Oral Health Workforce grant. They are contracting with the New York Oral Health Liaison through the AAP, helping to leverage support for primary care providers to do more fluoride varnish application in the medical setting. Additionally, there are efforts underway to increase fluoride varnish application in the medical setting through public health detailing of pediatric and family medicine practitioners by local health departments (LHDs). Under NYSDOH's State Oral Health Workforce grant from HRSA, NYSDOH has initially partnered with seven LHDs (Cayuga, Jefferson, Madison, Lewis, Oswego, Saratoga, and St. Lawrence) to conduct one-on-one visits with the primary care practices in their community to enhance staff capacity to perform oral health screening and fluoride varnish application to children. A series of trainings were held for LHDs from August 2020 – August 2021, with LHDs conducting public health detailing visits from May 2021 – August 2022. Resources for patients and providers have also been developed as part of this initiative, including a continuing education training for medical providers and public health detailing kit containing 16 materials entitled "Children's Oral Health Kit." This kit will be distributed to providers at the detailing visit. This is a 4-year grant (September 1, 2018 – August 31, 2022). Additional LHDs may be trained prior to the grant's conclusion.

### Goal 3: Promote Effective and Comprehensive Prevention and Management of Chronic Disease

In the United States, 6 in 10 adults have a chronic disease and 4 in 10 adults have two or more chronic diseases. Chronic diseases, such as asthma, cancer, diabetes, heart disease, and stroke, are the leading cause of death and disability in the nation and account for most of the nation's health care costs.<sup>13</sup> Over the five-year period of 2011-2016, only a quarter of adults in NYS had no chronic condition, while another quarter had one condition, and more than half had two or more.<sup>14</sup> Multiple chronic conditions exist at a higher prevalence in those with public insurance and those with lower household income, speaking to the importance of promoting the management of chronic disease in the NYS Medicaid and CHPlus population.

While chronic conditions are responsible for major disruptions in daily life and high health care costs, they are also among the most preventable.<sup>15</sup> Chronic diseases can be prevented by addressing risk behaviors like tobacco use, poor diet, and lack of physical activity, while effective management entails early diagnosis and intervention to prevent complications.

It has been observed that a large amount of Medicaid spending has been on services for individuals with multiple chronic conditions, frequent hospital utilization, and unstable access to community based medical care. Improving care management among this population requires a holistic approach, not just addressing immediate medical needs, but coordinating care that encompasses medical, social, and behavioral issues.<sup>16</sup>

**Table 3:** Metrics, Baseline Rates, and Target Rates for *Promote Effective & Comprehensive Prevention and Management of Chronic Disease* (A1:G3)

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#5: Comprehensive Diabetes Care: HbA1c Testing (ages 18 - 64 years)	93%	94%
#6: Asthma Medication Ratio	66% (ages 5-18) 55% (ages 19-64)	67% 56%
#7: Controlling High Blood Pressure (ages 18 - 64 years)	67%	68%
#8: Follow-up After Emergency Department Visit for Mental Illness within 30 days (FUM)	72%	73%

### **Interventions**

#### **New York State Medicaid National Diabetes Prevention Program (CC, SDH)**

In September 2019, the National Diabetes Prevention Program (DPP) was added as a covered benefit for NYS adult Medicaid members to address the increasing challenges of prediabetes and type 2 diabetes in NYS. An estimated 1.7 million or 11% of adult New Yorkers have been



diagnosed with diabetes as of 2018, an increase in prevalence of 4.7% since the year 2000,<sup>17</sup> and an additional 1.4 million (10.4%) of New Yorkers are estimated to have been diagnosed with prediabetes.<sup>18</sup> Without lifestyle changes, 15-30% of those with prediabetes will develop type 2 diabetes within 3-5 years.<sup>19</sup> In the United States, the average annual cost of treating adult Medicaid members with diabetes is \$13,490, compared to \$5,133 for Medicaid members without diabetes. Low-income New Yorkers bear a disproportionate burden of type 2 diabetes, and NYS Medicaid considers this evidence-based program a wise and solid investment in the future health of New Yorkers. The DPP contributes to the meaningful use of health information technology and exchange by utilizing the prediabetes registry functionality of the electronic health record (EHR) to identify eligible DPP participants, as well as electronic communication, data exchange, and care coordination between and across healthcare and community DPP delivery partners.

The NYSDOH Division of Chronic Disease Prevention assists health care organizations in implementing systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for type 2 diabetes prevention. NYS evaluates these efforts by tracking access to and availability of DPP in targeted areas, the number of people with prediabetes identified and referred to DPP, participation and retention in DPP, and outcomes (achievement of 5 percent weight loss) among eligible participants. Qualitative information, such as barriers and facilitators to implementing referral systems and increasing participation and retention in DPP, is also collected.

### **Behavioral Health Integration (CC)**

Historically, fragmented care has contributed to high utilization of inpatient services, e.g., 20% of patients discharged from psychiatric inpatient units were readmitted within 30 days to any hospital's inpatient unit for mental health cause.<sup>20</sup> Also, the majority of preventable admissions paid for by Medicaid FFS to Article 28 inpatient hospitals are for people with behavioral health conditions, yet the majority of expenditures for these members are for chronic physical health conditions.<sup>21</sup>

NYS's Delivery System Reform Incentive Payment (DSRIP) program, an 1115 Waiver demonstration implemented 2015-2020, focused on system integration, clinical quality, and population health improvement to achieve reductions in avoidable hospital use. Integrated services, specifically DSRIP project 3.a.i, "Integration of primary care and behavioral health services" and the Integrated Outpatient Services (IOS) licensure, were a significant focus of the program and each of the lead health systems. The IOS licensures, which allowed Article 28, 31, and 32 outpatient settings the ability to add services provided under the licensure or certification of one or both of the other Articles, was introduced to foster integration of behavioral and physical health services. While the DSRIP program formally concluded in 2020, the integration of primary care and behavioral health services continue through a variety of mechanisms. Health care providers have long recognized that many patients have multiple physical and behavioral health care needs, yet services were traditionally provided in separate settings. The integration of primary care with mental health, and/or substance use disorder services can help



improve the overall quality of care for individuals with multiple health conditions by treating the whole person in a more comprehensive manner. This integration may include bringing primary care services into a behavioral health setting, the converse of bringing behavioral health services into a primary care practice, or third, the collaborative care “Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)” model.

A primary metric to assess integrated services is a decrease in avoidable hospital utilization among the behavioral health population. In the DSRIP program, a tailored *Potentially Preventable Emergency Room Visits* measure was used to assess rates of potentially preventable utilization. An Independent Evaluator was engaged to evaluate the DSRIP program through assessment of both the quantitative and qualitative aspects of the Waiver Program. A formal assessment of the program is currently being completed by the Independent Evaluator, with preliminary results indicating most of the program’s Performing Provider Systems (PPSs) were able to reduce Potentially Preventable Emergency Room Visit rates among the behavioral health population.<sup>22</sup> For total cost of care arrangements in value-based payment contracts, the pay-for-performance measure of *Potentially Preventable Mental Health-Related Readmission Rate in 30 Days* is available for inclusion among metrics to determine shared savings or losses. Behavioral health integration is also a key component of the vision for pediatric population health recommended in the report by the First 1000 Days on Medicaid Initiative’s Pediatric Preventive Care Clinical Advisory Group.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/first\\_1000.htm](https://www.health.ny.gov/health_care/medicaid/redesign/first_1000.htm)

### **Improving Asthma Control to Reduce Avoidable Asthma Emergency Department Visits and Hospitalizations (CC, SDH)**

Asthma is one of the most common chronic conditions among children with 200,000 children in NYS living with asthma. Additionally, over 1.5 million adults in NYS currently have asthma.<sup>23</sup> During 2018, asthma caused over 134,000 emergency department visits and nearly 20,000 hospitalizations in NYS.<sup>24</sup> Since 2002, with state and federal funding, the NYS Asthma Control Program (ACP) has worked to expand the successful implementation of interventions designed to improve the quality and availability of guidelines-based asthma care to reduce asthma-related mortality, avoidable emergency department (ED) visits, and hospitalizations. The ACP guides statewide expansion of quality improvement in asthma care and availability of comprehensive asthma services delivered in accordance with National Asthma Education and Prevention Program’s Asthma Guidelines (NAEPP Guidelines) in the highest asthma burden regions in NYS to reduce asthma-related disparities. Target populations include low-income, Medicaid/CHPlus-eligible children and adolescents with asthma (age 0 to 17) and their families/caregivers statewide. Asthma is a priority in the NYSDOH’s statewide initiatives to advance health care reform including: the DSRIP program; NYS’s transformation of Medicaid to

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a value-based purchasing (VBP) framework to sustain DSRIP investments; and the NYS Prevention Agenda 2019-2024.

The ACP fosters collaboration across sectors and systems statewide and engages regional and local level partners and funded contractors to ensure coordination of evidence-based asthma services aimed at improving the lives of Medicaid members with asthma and their families/caregivers. ACP efforts and interventions span state agencies, local health departments, health care systems, hospital associations, health plans (payers), and CBOs to support linkages across public health and health care delivery systems to improve comprehensive asthma control services. Primary areas of intervention include the expansion of access to quality medical management of asthma and individually tailored asthma self-management education (ASME) in multiple settings including the home, community, school, and clinic. The ACP implements interventions in alignment with evidence-based guidance from the [CDC National Asthma Control Program](#), which funds the ACP. CDC provides funding to more than twenty states and cities to apply strategies outlined in the [EXHALE technical package](#) (EXHALE) which is designed to meet CDC's [Controlling Childhood Asthma, Reducing Emergencies](#) (CCARE) initiative goals. CCARE aims to prevent half a million hospitalizations and ED visits among children with asthma by 2024. EXHALE, using best available evidence, drives the improvement of asthma control to achieve a reduction in avoidable health care costs. Strategies include: Education on asthma self-management (E); Extinguishing smoking and second-hand smoke (X); Home visits for trigger education and asthma self-management education (H); Achievement of guidelines-based medical management (A); Linkages and coordination of care across settings (L); and, Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources (E). All ACP-supported initiatives incorporate every EXHALE strategy. Examples of interventions coordinated by the ACP in partnership with NYS-funded contractors and partners, which align with NYS's Prevention Agenda and multiple health care reform initiatives, include:

- Providing clinical and quality improvement resources and training to clinical sites to support the delivery of guidelines-based medical care, including working with health systems to develop and implement asthma templates into their EHR systems to increase the meaningful use of health information technology;
- Engaging home nursing agencies and CBOs delivering home-based asthma services to provide training and resources to ensure in-home asthma services include multi-component approaches to asthma trigger reduction and self-management education for high-risk patients;
- Building cross-sector linkages between health, housing, and energy to advance NYS's "health across all policies" approach and integrate related initiatives into NY's VBP framework, in partnership with MCOs, to ensure sustainability;
- Promoting evidence-based approaches to delivery of ASME across providers and settings (clinical, home, school, or community);
- Driving collaborations across settings (home, school, community, and clinical) to build bi-directional communication and referral systems structured to support care coordination for people with asthma; and

- Partnering with stakeholders to facilitate and promote environmental policies designed to support asthma control (e.g., smoke-free school grounds, anti-idling, and clean diesel policies), regionally and statewide.

The ACP uses the CDC's *Learning and Growing Through Evaluation* to guide all evaluation activities, which are critical to program success. This approach actively engages strategic partners and stakeholders to develop a broad Strategic Evaluation Plan (SEP) and more detailed project-specific Individual Evaluation Plans (IEPs). The ACP works closely with partners to identify and ensure access to data sources needed for the implementation of the SEP and the IEPs. The ACP engages key partners and stakeholders through meetings, presentations, and document review, to play an ongoing central role in evaluation activities. Programs and interventions are monitored through the reporting of process measures, and ongoing feedback is provided to partners to ensure consistency in data collection and data quality. Evaluation progress and findings are shared with partners and stakeholders to reinforce engagement, assess implementation, drive program effectiveness and efficiency, and expand successful strategies related to EXHALE services and coverage of comprehensive asthma services and medications. Where feasible, evaluation activities include economic evaluations to support business cases aimed at expanding coverage of asthma services and medications. However, further development of cost and return on investment (ROI) measures on a national level is needed. As indicated above, evaluation for all interventions is guided, informed, and assessed by several types of measures:

- Population health surveillance measures – These measures assess overall asthma burden throughout the state, help identify high-burden regions, and assist in targeting intervention activity. They are also used to evaluate and assess how NYS is progressing toward overall goals of asthma control;
- Clinical quality measures – These measures are used to drive intervention activities and monitor progress. They help achieve partner buy-in as they align with required reporting of national and state-level measures;
- Quality Improvement/EHR measures – These measures are used in learning collaboratives and facilitated Quality Improvement (QI) to help participating sites track their site-level performance, measure impact of changes in workflow and clinical practice, and evaluate outcomes of QI initiatives; and
- Intervention-level measures – These measures are collected through intervention data collection tools. Patient-level intervention and self-report data help assess impact of interventions on patient symptoms, health service utilization, and quality of life outcomes.

### **Controlling High Blood Pressure (CC, SDH)**

To address the burden of cardiovascular disease (CVD), specifically hypertension (HTN), the CVD Prevention and Control Program is focused on implementing and evaluating five evidence-based strategies to improve the control of HTN in the primary care setting, in partnership with

the NYS Primary Care Association and Community Health Center Association of NYS (CHCANYS). CHCANYS represents 70 Federally Qualified Health Centers (FQHCs) and their 800 associated sites across NYS. FQHCs have disparate populations who are uninsured or underinsured. Socioeconomic status is an important determinant of health; 13.7% of adults in NYS live below the federal poverty level.

Strategies include:

1. Support FQHCs in monitoring and tracking patient and population-level clinical quality measures for HTN prevalence, HTN control, and undiagnosed HTN;
2. Support providers in the use of patient-/population-level HTN registries that are stratified by age, gender, race, and ethnicity;
3. Support practices in implementing team-based approaches to care using patient HTN registries and electronic pre-visit planning tools;
4. Support FQHCs in referring patients to home blood pressure monitoring with provider follow-up; and,
5. Support FQHCs in implementing bi-directional referrals to community-based programs that support patients in their chronic disease self-management.

Evaluation of the CVD Prevention and Control Program includes monthly tracking and monitoring of aggregate practice-level measures for HTN (prevalence, control, and undiagnosed). Provider and practice teams receive reports on the measures to inform quality improvement efforts. Practices do not receive incentive payments, though they receive support from Practice Facilitators to implement strategies and adopt policies and protocols for HTN.

### **Care Management for All – Adult Health Homes (CC, SDH)**

Implementation of Health Homes for Medicaid enrollees with chronic conditions was recommended by Governor Cuomo’s Medicaid Redesign Team. As a result, this initiative was included in the Governor’s 2011-12 State Budget and was adopted into law effective April 1, 2011. Social Services Law (SSL) Section 365–L authorized the Commissioner of Health, in collaboration with the Commissioners of OMH, OASAS, and the Office for People with Developmental Disabilities (OPWDD), to establish health homes for NYS Medicaid enrollees with chronic conditions.

To be eligible for adult Health Home services, Medicaid members must have either two or more chronic conditions, or HIV, or Serious Mental Illness (SMI). Members must be appropriate for the intensive level of care management services provided by the Health Home. If a condition is well managed by the Medicaid member without services, Health Home services would not be appropriate.

Medication adherence and proper follow-up after an ED visit are two areas where Health Home Care Managers are uniquely positioned to support their members by means of care coordination

and health promotion; this is especially true for Health Home members with SMI. Care Management efforts can lead to better health outcomes and avoidance of unnecessary hospitalizations by getting and keeping a member engaged in outpatient services, as well as following treatment recommendations (e.g., medication adherence). One of the key indicators related to this population includes the rate of follow-up after an ED visit for mental illness. Care managers have access to alerts from their Regional Health Information Organization (RHIO) to notify them of a member entering the ED so that the proper transitional and follow-up care can take place, with the intent to avoid the need for future use of the ED. Specifically for members diagnosed with schizophrenia, another calculated indicator is the rate of antipsychotic medication adherence. Care Managers can support a member with reminders and encouragement to take medications as prescribed, coordinate nursing services to pre-pour medication as needed, as well as troubleshoot insurance issues that may prevent a prescription from being filled on time.

As with all performance measures for the Health Homes program, the Office of Health Insurance Programs (OHIP) works closely with the Office of Quality and Patient Safety (OQPS) to calculate the 30+ performance measures that are reported for the program. On a quarterly basis, OHIP receives an update from OQPS for the performance measure rates on a 12-month rolling year time frame that is continually updated. The performance measures are shared with Health Homes quarterly. There are also additional tools made available to Health Homes and their Care Management Agencies through the Medicaid Analytics and Performance Portal (MAPP) that update a subset of these measures, as well as other metrics about their network including enrollment, subpopulation data, and general metrics about the volume and types of interventions being carried out by the program. To emphasize performance, OHIP uses a scoring rubric, which includes these performance measures, to determine the length of a Health Home's designation.

### **Transitioning the Foster Care Population into MMC**

The transition of the foster care population to MMC is part of NYS's overall redesign of children's healthcare and behavioral health systems. In 2013, approximately 3,200 children in foster care who were in the direct care of local department of social services districts outside of New York City (NYC) were enrolled into managed care. These children account for approximately 20 percent of the foster care population in NYS. Approximately 80 percent of children in foster care, who are cared for through a voluntary foster care agency, are currently not enrolled in managed care.

In 2021, the State transitioned children in the care of Voluntary Foster Care Agencies (VFCAs) into mandatory managed care. To facilitate this transition, the State will issue licenses to qualified VFCAs pursuant to Article 29-I of Section 1 of the Public Health Law (PHL). VFCAs that intend to enter into contracts with managed care plans must apply for and receive licensure under this statute, consistent with Corporate Practice of Medicine. VFCAs, serving principally as facilities for the care of and/or boarding out of children, shall be subject to the provisions of Article 29-I of the PHL and applicable state and federal laws, rules, and regulations.

Licensure allows the 29-I Health Facility to deliver two sets of services: Core Limited Health-Related Services and Other Limited Health-Related Services. The licensed 29-I Health Facilities will be required to provide Core Limited Health-Related Services, which include Nursing, Skill Building, Medicaid Treatment Planning and Discharge Planning, Clinical Consultation/Supervision, and VFCA Medicaid Managed Care Liaison/Administration. Licensure will also allow the 29-I Health Facility to provide certain Other Limited Health Related Services that are specified on the license. Applications for 29-I Licenses have been reviewed and approved by the NYSDOH and OCFS, including an on-site review component to ensure the facilities meet prescribed standards and guidelines. OCFS will monitor compliance on an ongoing basis.

NYS expects that the transition will improve the overall quality of care for children/youth being cared for by the 29-I Health Facilities/29-I VFCAs by standardizing the care model and improving access to services. Enrollment in managed care will expand the network of providers that children/youth in foster care have access to, with the aim of leading to increased and timely access to essential community providers and needed services. Licensed 29-I Health Facilities, in collaboration with MMC plans, will manage health services, ensure children/youth receive the least restrictive health care, and monitor for quality service provision. Defining quality care for children/youth in foster care and establishing quality measures specific to this population are ongoing.

### **Usage of Care Coordination and Provider Supports in VBP**

Care management and care coordination, historically non-reimbursable activities in Medicaid except in targeted programs, were implemented in NYS's DSRIP program to support care integration and improve member well-being across the care spectrum.

Care coordination has proved particularly relevant for the state's special needs populations including members with SMI and/or substance use in HARPs, members in MLTC, members with HIV and AIDS, and members of FIDA (Fully Integrated Duals Advantage) populations with intellectual and developmental disabilities. For these populations, care coordination has played an increasingly important role given the propensity, historically, for wide variation (*higher costs and poorer outcomes*).

Assistance with transitions in care, establishing accountability, agreeing on responsibility, creating a proactive care plan, monitoring and follow-up, providing linkages to community resources, and providing medication management services for members are just a few of the ways care coordination activities contribute to newly realized efficiencies and provide higher value care to Medicaid members.



The use and promotion of warm hand-offs are directly associated with properly executed care coordination and are not only beneficial and responsive to the patients' needs, but also serve the delivery system by reducing avoidable ED visits and hospital admissions, promoting patient education around appropriate usage of care across the care spectrum, and supporting the effective integration of care by assuring Medicaid members gain access to appropriate outpatient care services, whether they be primary care, behavioral health care, or specialty care.

In 2011, the NYS Health Foundation reported that many inpatient stays lead to readmissions with an overall annual readmission rate of 14.6% as of 2008.<sup>25</sup> Likewise, in, the 2009, the Commonwealth Fund ranked NYS 50<sup>th</sup> on the measure of avoidable hospital use and costs,<sup>26</sup> however, by 2020, evidence continued to emerge that NYS has made demonstrable improvement, and is now ranked 28<sup>th</sup> nationwide in avoidable hospital cost and use.<sup>27</sup> While all readmissions are not preventable, many readmissions result from hospital-acquired infections, premature discharges, failures in medication management, inadequate discharge planning, or poor communication with patients and providers responsible for discharge care.<sup>28</sup> Care coordination emerged to address these factors.

Care coordination is supported by Qualified Entities, regional health information exchanges (HIEs) connected by the SHIN-NY, to improve electronic exchange of clinical information between healthcare professionals and systems statewide. The goals of the HIEs are to enhance collaboration and coordination of care to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs.

Care coordination, by its nature, aims to meet patients' needs and preferences at the right time in the right place and ensure the information is used to guide the delivery of safe, appropriate, and effective care<sup>20</sup> Establishing the appropriate electronic health record infrastructure and interoperability standards to ensure better communication among health care professionals within and between systems through the SHIN-NY has been associated with:

- a 50% reduction in the rate of hospital admissions;
- a 26% reduction in the rate of ED admissions; and
- a 35% reduction in the rate of repeat imaging procedures.<sup>29</sup>

Through the first 4 years of the DSRIP Program, the success of statewide efforts to improve care coordination and patient-centered care within the healthcare delivery system has been demonstrated by significant decreases in indicators of avoidable hospital utilization, such as Potentially Preventable Admissions and Potentially Preventable Readmissions.<sup>22</sup>

NYS has demonstrated through its DSRIP program that by supporting care coordination activities, greater benefits are extended to both the member and the comprehensive care teams that support them. Along with meaningful use of Health Information Technology (HIT) platforms that support care coordination efforts and multidisciplinary care teams that enhance integration, the implementation of care coordination should free up time for practitioners in primary and specialty care to provide more face-to-face care to their patients. By establishing a robust care team where care coordination becomes an integral component of a patient-centered strategy, the efficiency of care team operations improves, which is critical to address administrative burdens.

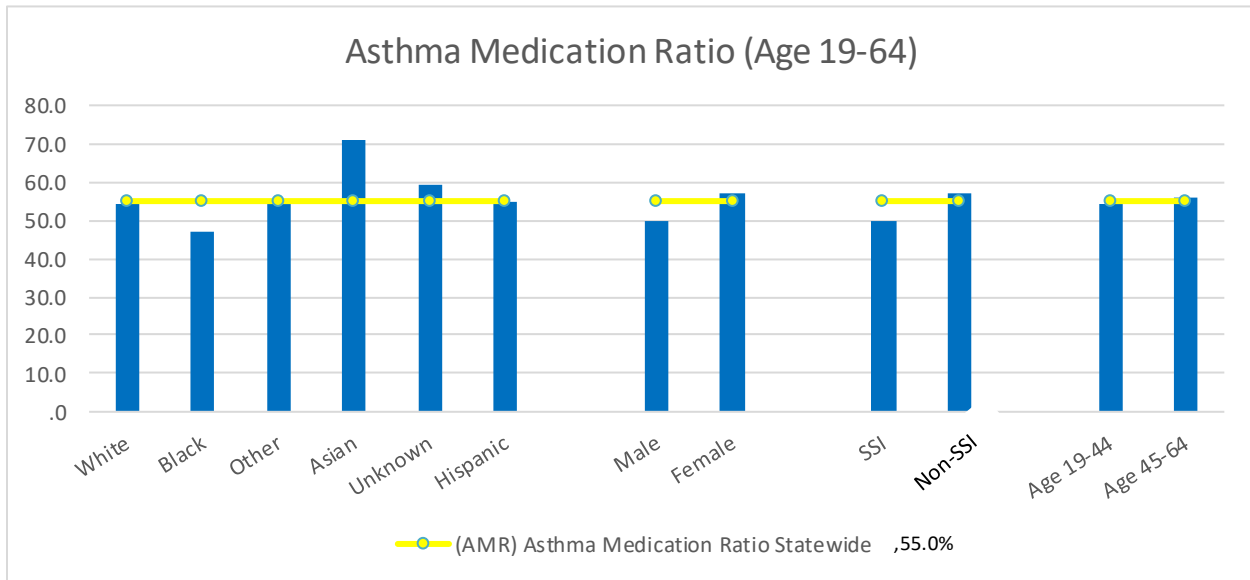
### Spotlight on Disparities: Chronic Disease

Disparities in the prevalence of chronic disease and their impact on the quality of care received and the outcomes associated with chronic diseases are well established. In recent years, the NYSDOH has made a concerted effort to promote the delivery of health care that is culturally competent as it seeks to achieve health equity, the elimination of disparities, and improved health for all New Yorkers. Two chronic disease quality measures are presented here for baseline year 2019.

Variation was observed in the 2019 Asthma Medication Ratio (Age 19-64) measure (Figure 2). Populations with rates below the statewide average of 55% included Black enrollees (47%), males (50%), and recipients of SSI (50%).

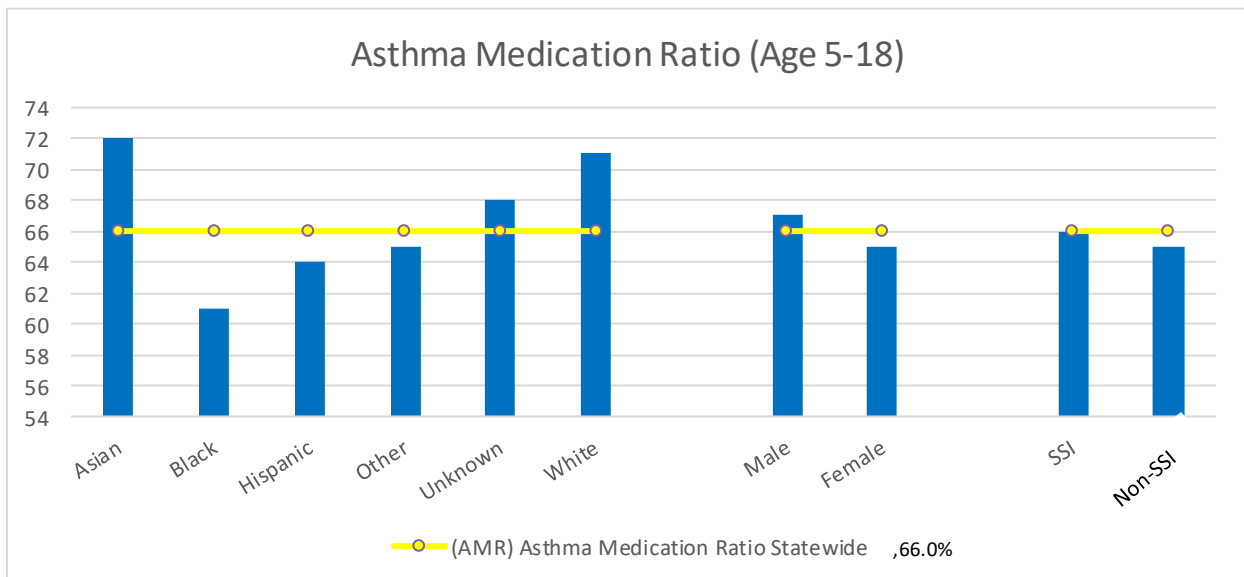


**Figure 2: 2019 Asthma Medication Ratio (Age 19-64) Stratified by Enrollee Demographics**



Variation was observed in the 2019 Asthma Medication Ratio (Age 5-18) measure (Figure 3). Populations with rates below the statewide average of 66% included Black enrollees (61%), Hispanic enrollees (64%), other enrollees (65%), females (65%), and individuals who are not recipients of SSI (65%).

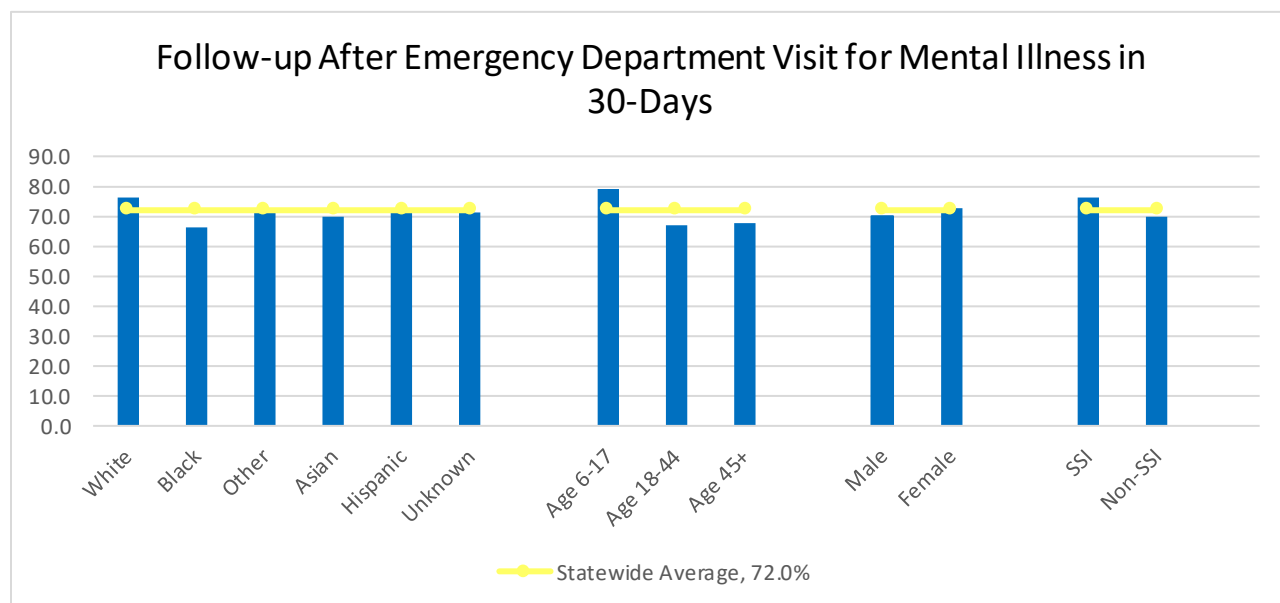
**Figure 3: 2019 Asthma Medication Ratio (Age 5-18) Stratified by Enrollee Demographics**



Finally, to assess disparities in the care provided to enrollees with mental illness, stratified rates of the 2019 *Follow-up After Emergency Department Visit for Mental Illness in 30-Days* are presented in Figure 4. Statewide, 72.0% of members received follow-up within 30 days,

however, those who did not receive SSI (70%), Black enrollees (66%) and those age 18-44 (67%) and 45+ (68%) all had lower rates.

**Figure 4:** 2019 Follow-up After Emergency Department Visit for Mental Illness in 30-Days Stratified by Enrollee Demographics



#### Goal 4: Promote the Integration of Suicide Prevention in Health and Behavioral Healthcare Settings

Suicide is a major public health problem for the nation and NYS. Each year, approximately 1,700 New Yorkers die by suicide, ranking it 6<sup>th</sup> in the nation for overall suicide burden. Between 2000 and 2018, the suicide rate in NYS increased 40.6% from 5.9 to 8.3 per 100,000 population, surpassing annual deaths by homicide and motor vehicle crashes.<sup>30</sup> In addition to deaths by suicide, there were 21,259 hospitalizations and ED visits for suicide attempts and self-inflicted injuries in 2016 alone.<sup>30</sup> Another 539,000 New Yorkers had suicidal thoughts.<sup>31</sup> The number of friends and family members of those who have thought about, attempted, or died by suicide is exponential, the grief of which greatly expands the scope of the problem.<sup>32</sup>

**Health System Contact and Suicide** - It is well established that individuals who die by suicide often have had recent contact with the healthcare system prior to death.

- Nearly half of suicide decedents have a primary care visit within 30 days of their death, compared to approximately 15-20% who receive mental health services within the same time frame.<sup>33</sup>

- Similarly, individuals at risk for suicide commonly present to EDs. Studies suggest approximately 8% of individuals presenting to EDs for non-behavioral health-related issues have active suicidal ideation, highlighting the need to universally screen. <sup>34,35</sup>
- Those presenting to EDs for deliberate self-harm die by suicide at a rate nearly 60 times higher than the general population, while individuals presenting for an accidental overdose die by suicide at a rate over 300 times higher than the general population in the year after the index ED visit. <sup>35,36</sup>
- Individuals admitted to a hospital psychiatric unit, even those presenting for things other than suicide, are also at much greater risk for suicide than the general population. <sup>37</sup> The immediate post-discharge period has been highlighted as a particularly high-risk time for this cohort, underscoring the need for improvements in care transitions. <sup>38,39</sup>

**Table 4:** Metrics, Baseline Rates and Target Rates for *Promote the Integration of Suicide Prevention in Health and Behavioral Healthcare Settings (A1:G4)*

Metric	Baseline	Target
#9: Depression Screening and Testing	TBD	TBD
#10: Depression Screening and Follow-up for Adolescents and Adults (DSF-E)	TBD	TBD

*\*Measure rates are not yet available but will be included and tracked in subsequent years.*

## **Interventions**

### **The Zero Suicide Model (CC, SDH)**

Taken together, the lines of evidence above are the basis for calls to formally and systematically integrate suicide prevention into health and behavioral healthcare systems—sometimes referred to as the Zero Suicide model. For example, in 2018 the Joint Commission established [National Patient Safety Goal 15.01.01](#) for preventing suicides within its accredited hospitals.

While adaptations to the model are made depending on the setting, the overall Zero Suicide approach calls for:

1. A fundamental commitment from health system leadership to reduce suicide attempts and deaths among those receiving care;
2. Systematic screening and assessment for the identification of those at risk;
3. Delivery of evidence-based interventions by a competent and caring workforce;
4. Monitoring of those at risk between care episodes, especially care transitions; and
5. Data-driven quality improvement to track and measure progress.

**Zero Suicide Implementation in NYS** - Led by the Suicide Prevention Office at OMH and partners, NYS is working with health systems across the state to support the voluntary adoption of the Zero Suicide model. This work is a core part of the [NYS Suicide Prevention Plan](#). Major demonstration projects are underway in Article 31 licensed mental health clinics, inpatient psychiatric units, substance use disorder settings, Comprehensive Psychiatric Emergency Programs (CPEPs), medical EDs, and primary care.

### Goal 5: Prevent and Reduce Nicotine, Alcohol, and Substance Use Disorder

Smoking is the number one cause of preventable disease, disability, and death in the United States.<sup>40</sup> In NYS, smoking kills about 28,000 adults every year, and about 750,000 adult New Yorkers live with serious smoking-related illness. Despite adult smoking rates reaching record lows, approximately 2.2 million adult New Yorkers still smoke. Smoking rates are highest among adults with lower income, lower educational attainment, and mental illness. The 2018 statewide adult smoking prevalence was estimated to be 12.8% but was 20.4% among those with incomes less than \$25,000.<sup>41</sup> For those in Medicaid specifically, smoking prevalence is estimated to be 23% among members. In total, tobacco-related health care costs in NYS are approximately \$10.4 billion annually, of which, Medicaid covers \$3.3 billion.<sup>42,43</sup>

A study published in JAMA Psychiatry in September 2017 analyzed the results from the National Epidemiologic Survey on Alcohol and Related Conditions over a 10-year span and concluded that “increases in alcohol use, high-risk drinking, and DSM-IV alcohol use disorder constitute a public health crisis especially among women, older adults, racial/ethnic minorities, and the socioeconomically disadvantaged.” NYS is also affected by the national public health crisis created by alcohol use. Averages from the 2016 and 2017 National Surveys on Drug Use and Health (NSDUH) estimate that 6.02% of New Yorkers over 18, or slightly less than one million people have an alcohol use disorder (AUD). The percentage of NYS adults with an AUD is higher than both the national rate of 5.82% and the Northeast U.S. rate of 5.97%.<sup>44</sup>

According to the National Survey on Drug Use and Health, in 2018 approximately 20.3 million people aged 12 or older had a SUD during the prior year, including 14.8 who had AUD and 8.1 million who had an illegal drug use disorder. Common disorders seen among those 8.1 million people who had an illegal drug use disorder included use of marijuana (4.4 million), misuse of prescription pain relievers (1.7 million), use of methamphetamine (1.1 million) and cocaine, prescription stimulant misuse and heroin (each <1 million).<sup>45</sup>

Performance targets for Metric #11 and Metric #12 in Table 5 were calculated using the lower confidence interval of the most recent year of data, as described under the baseline column. The baseline data is based on the YRBSS and the NSDUH. The Performance target for Metric #13 in Table 5 was calculated by looking at the endpoints of the most recent 5 years of data and then predicting forward a linear change based on the annual decrease. The smoking prevalence was 25.1% in 2015 and 23.0% in 2019 which is a 2.1%-point change over 4 time periods. The average change in prevalence was 2.1%/4 or .525 percentage points annually. By predicting forward a linear change for the next three years (3 X .525% annual or 1.6% total change), the performance target of 21.4% smoking prevalence in three years was established. The baseline data for smoking prevalence is based on BRFSS.

**Table 5:** Metrics, Baseline Rates and Target Rates for *Prevent and Reduce Nicotine, Alcohol, and Substance Use Disorder (A1:G5)*

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#11: Percentage of high school students reporting current use of alcohol, binge drinking, marijuana, on at least one day during the past 30 days (YRBSS*; YDS)	Alcohol: 26.4% (YRBSS, 2019) Binge: 12.7% (YRBSS, 2019) Marijuana: 19.1% (YRBSS, 2019)	Alcohol: 23.6% Binge: 10.8% Marijuana: 17.1%
#12: Percentage of adult use of binge alcohol, marijuana, cocaine, heroin, other drugs (NSDUH)	Alcohol Binge: 25.48% (past month; NSDUH, 2017-18) Marijuana: 10.05% (past month; NSDUH, 2017-18) Cocaine: 2.82% (past year; NSDUH, 2017-18) Heroin: 0.3% (past year; NSDUH, 2017-18)  Illicit Drug Use Other Than Marijuana: 3.42% (past month; NSDUH, 2017-18)	Alcohol Binge: 24% Marijuana: 9.14% Cocaine: 2.37% Heroin: 0.17%  Illicit Drug Use Other Than Marijuana: 2.94%
#13: Medicaid smoking prevalence (Calculated from BRFSS Survey Data)	23% (BRFSS, 2019)	21.4%

\* YRBSS is a system of surveys. It includes 1) a national school-based survey conducted by CDC and state, territorial, tribal, and 2) local surveys conducted by state, territorial, and local education and health agencies and tribal governments. Metric #11 is the results of a survey of a subset of high school students across NYS and is not stratified by insurer.

### **Interventions**

#### **Provide a Comprehensive Smoking Cessation Benefit**

Due to the addictive properties of nicotine, quitting is difficult. Therefore, both behavioral interventions (counseling) and pharmacotherapy are recommended to improve abstinence rates. NYS Medicaid provide comprehensive coverage of smoking cessation pharmacotherapy agents (all seven classes of smoking cessation medication approved by the U.S. Food and Drug Administration) and smoking cessation counseling (SCC) for all Medicaid enrollees, without cost

sharing, prior authorization requirements, or limits on quit attempts. Enrollees are allowed concurrent use of products (two or more medications at once). Medicaid also pays for over-the-counter nicotine patches, gum, and lozenges (with a prescription from a provider).

Those enrolled in MMC plans receive their pharmacotherapy benefits directly through their plans, with some variation by plan regarding which products are offered (generic equivalents for brand name medications). Cessation counseling, both Intermediate (3-10 minutes) and Intensive (greater than 10 minutes in individual or group setting), can be provided by office-based practitioners, including dental hygienists, as well as by providers in Article 28 hospital outpatient departments, diagnostic and treatment centers, and federally qualified health centers. Quality improvement efforts will focus on increasing the use of these evidence-based tobacco cessation services and ultimately decreasing the prevalence of smoking.

### **The New York State Smokers' Quitline (CC, SDH)**

The New York State Smokers' Quitline serves as a clinician treatment extender in NYS's population-level, evidence-based approach to cessation, which focuses on health system changes to increase the delivery of tobacco dependence treatment, especially for subpopulations with high smoking prevalence, including Medicaid enrollees. The free and confidential Quitline provides resources and technical assistance to assist Medicaid enrollees and other disparate populations in accessing and using cost-effective cessation benefits. In 2019, the Quitline provided quality cessation services, including evidence-based quit coaching, materials, and referrals via telephonic and web-based services, to over 36,000 New Yorkers. Services are provided in English and Spanish, with interpretation available for 140 other languages, and referrals are made, when appropriate, to the Asian Quitline. The Quitline also provides free starter kits of nicotine replacement therapy (NRT) patches, gum, and/or lozenges to eligible New Yorkers. In 2019, more than 37,500 free starter kits of NRT were provided to 30,000 adult smokers in NYS.

Through the NYSDOH's cooperative agreement to enhance Quitline capacity, funds are used to promote cessation messaging to Medicaid enrollees. Among those who provided insurance status to the Quitline, there was an approximate 13.5% change in the number of Medicaid and uninsured individuals receiving treatment from the Quitline, increasing the overall percentage from 54% in 2013-2014 to 61.3% in 2017-2018.

### **Mass-Reach Health Communications (CC, SDH)**

The NYSDOH implements evidence-based, strategic, culturally appropriate, and high-impact paid media campaigns targeted at tobacco-related disparate populations to prevent initiation, increase cessation, increase awareness and use of Medicaid tobacco cessation benefits and the Quitline, and prevent tobacco use relapse. Media campaigns are also targeted to medical and mental health care systems and providers to increase awareness of Medicaid reimbursement for cessation counseling and FDA-approved medications to increase the delivery of evidence-based, tobacco dependence treatment to enrollees who smoke or vape tobacco.

NYSDOH uses formative research to determine the best media mix to meet the health literacy level of the target audience and deliver the desired message. Identified advertisements are pretested with an online panel of smokers and recruited participants who report lower socioeconomic status to measure the ads' effectiveness prior to being placed. Ads and messages are selected that are most likely to elicit strong emotions or accurately depict the negative consequences of smoking, trigger quit attempts, motivate smokers to talk to their health care provider, and to call the Quitline for more help. Selected ads are tagged with a call to action for smokers to talk with their health care provider to break their addiction to smoking and to inform them that Medicaid and most health insurance can help. Outcome evaluation findings of the campaigns are used to adjust current campaigns and aid in developing future campaigns.

Special efforts to promote cessation ads to the Medicaid population began on December 29, 2014, and in 2016, NYSDOH began promoting Medicaid in all cessation media campaigns. Evaluation data indicate these ads reach their intended population, with 45% of Medicaid-enrolled smokers reporting awareness of the ads in 2016. Smoking rates among Medicaid enrollees have decreased from 25.1% in 2015 to 23.0% in 2019. While still higher than the overall adult smoking rate, the smoking rate among Medicaid enrollees is decreasing.

### **Prevention of Alcohol and Substance Use, Misuse, and Disorder**

The NYS OASAS Prevention Division follows the Strategic Prevention Framework (SPF) at the State and local level which includes a five-step, data-driven planning process designed to guide state and local communities in the selection, implementation, and evaluation of effective, culturally responsive, and sustainable prevention activities. Research has demonstrated that the use of the SPF process increases sustainable prevention infrastructure and reduces substance use.<sup>46,47,48</sup> In addition to the SPF, OASAS takes a comprehensive approach, making sure programming spans the three Institute of Medicine (IOM) continuum prevention intervention levels (universal, selective, and indicated), as well as across the levels of the socio-ecological model (individual, peer/family, school, and community), to achieve maximum impact.

The SPF process begins with a need's assessment including the collection of quantitative and qualitative data that, when analyzed, highlight areas of concern. Based on those analyses, programs and strategies are selected to effectively and efficiently meet contextual needs. Data analyses focus on substance use consumption patterns, risk (e.g., perceptions of risk associated with substance use, access to substances, conduct disorders), and protective factors (e.g., social competencies, family attachment, prosocial involvement).

Interventions OASAS supports include:

- Environmental change strategies;
  - Policies (e.g., alcohol advertising restrictions, social host liability laws)
  - Enforcement (e.g., party patrols, compliance checks, sobriety checkpoints)



- Media (e.g., social marketing campaign, media advocacy, social norms campaign)
- Community-based Substance Use Prevention Coalitions;
- Family-focused prevention programming (e.g., Strengthening Families, Triple P - Positive Parenting Program); and,
- School-based prevention curricula, to include:
  - Universal (e.g., Too Good for Drugs, PAX Good Behavior Game, Guiding Good Choices, Positive Action, Life Skills Training, Second Step)
  - Selective/Indicated (e.g., Teen Intervene, Preventure).

OASAS holds funded providers, early intervention programs that help youth who exhibit elevated risk factors and are using substances, as well as educational and multi-component programs which focus on improving risk and protective factors at home and in the community, to eight performance standards.<sup>49</sup> To monitor progress toward these standards, funded prevention providers enter implementation data into an electronic database system, called Web Infrastructure for Technology (NY) Services (WITNYS). The data are regularly reviewed by OASAS staff to measure progress towards those standards.

In addition, each funded prevention provider submits an annual report at the end of the fiscal year. Each funded prevention provider evaluates a portion of their prevention programming using a minimum of a pre- and post-survey evaluation designs and reports the results which are reviewed by a prevention scientist in the Division. Based on the outcomes associated with the programming, prevention providers adjust their program implementation to ensure that they continue to achieve positive outcomes and meet emerging needs.

### **Combating the Opioid Epidemic (CC, SDH)**

The NYSDOH supports many strategies to address the opioid crisis and reduce opioid use. The following are activities that the Medicaid program has done or is actively pursuing:

- Created policies to ensure appropriate use of opioids, some of which link up with legislation (State & Federal) and/or Drug Utilization Review Board (DURB) recommendations:
  - Limit Initial Opioid Prescribing to a Seven-Day Supply for Acute Pain- [https://www.health.ny.gov/health\\_care/medicaid/program/update/2016/2016-07.htm#opioid](https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-07.htm#opioid)
  - NYS Medicaid FFS Pharmacy Programs Prior Authorization/Coverage Parameters for Long-Acting and Short-Acting Opioids - pgs. 4-7, [https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_PDL.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf)
- Developed provider education materials such as:
  - Mailings- [https://www.health.ny.gov/health\\_care/medicaid/program/dur/communications/2018/](https://www.health.ny.gov/health_care/medicaid/program/dur/communications/2018/)



- CDC guideline for prescribing opioids for chronic pain
    - American Dental Association's interim policy on opioid prescribing guidelines
  - [https://www.health.ny.gov/health\\_care/medicaid/program/dur/communications/2019/019/](https://www.health.ny.gov/health_care/medicaid/program/dur/communications/2019/019/)
    - Concurrent use of antipsychotic and opioid medications related to the SUPPORT for Patients and Communities Act
    - SUD Treatment, MMC and FFS coverage
    - Concurrent gabapentinoid and opioid utilization
  - Medicaid Prescriber Education Program, which uses academic educator outreach to educate Medicaid prescribers on the latest research concerning medication usage and new updates on disease states. There is an educational module on chronic, non-cancer pain - <https://nypep.nysdoh.suny.edu/>
- Requires a written, opioid treatment plan be documented in the medical record of patients initiating or being maintained on opioids for pain that has lasted more than three months, or past the time of normal tissue healing. Exceptions are for patients being treated for cancer that is not in remission, hospice or other end-of-life care, and palliative care - pg. 8.  
[https://www.health.ny.gov/health\\_care/medicaid/program/update/2019/may19\\_mu.pdf](https://www.health.ny.gov/health_care/medicaid/program/update/2019/may19_mu.pdf)
  - Encourages the use of Non-Opioid Alternatives  
[https://www.health.ny.gov/health\\_care/medicaid/program/opioid\\_management/docs/non\\_opioid\\_alternatives\\_to\\_pain\\_management.pdf](https://www.health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf)
  - Increased access to drugs used for SUD treatment by:
    - Prohibiting prior authorization under Medicaid FFS and MMC for initial or renewal prescriptions for preferred or formulary forms of buprenorphine or injectable naltrexone when used for detoxification or maintenance treatment of opioid addiction - pg. 24,  
[https://www.health.ny.gov/health\\_care/medicaid/program/update/2016/aug16\\_mu.pdf](https://www.health.ny.gov/health_care/medicaid/program/update/2016/aug16_mu.pdf)
    - Requiring Medicaid FFS and MMC to provide at least 5 days of coverage for emergencies, without prior authorization, for medications used to treat SUD. This includes medication associated with the management of opioid withdrawal and/or stabilization, as well as medication used for opioid overdose reversal. Additionally, no additional copayment or coinsurance shall be imposed on an insured who received an emergency supply of medication and then received up to a thirty-day supply of the same medication in the same thirty-day period in which the emergency supply of medication was dispensed.  
[https://www.health.ny.gov/health\\_care/medicaid/program/update/2016/2016-12.htm#substance](https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-12.htm#substance)

- Participated with other Department of Health offices in the CDC's Prescription Drug Overdose Prevention (PDOP) initiative and is now working with these same partners on the Overdose Data to Action initiative.
- Supported broad screening for OUD/SUD in primary care practices through DSRIP program.
- Supported DSRIP program's Promising Practices, specifically Medication-Assisted Treatment (MAT) expansion to primary and ED care settings and SUD peer bridging. <https://uhfnyc.org/publications/publication/dsrp-promising-practices/>

There is also Statewide Mandatory Prescriber Education: Prescribers licensed in NYS to treat humans and who have a Drug Enforcement Administration (DEA) registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course work or training in pain management, palliative care, and addiction every three years. [https://www.health.ny.gov/professionals/narcotic/mandatory\\_prescriber\\_education/](https://www.health.ny.gov/professionals/narcotic/mandatory_prescriber_education/) Medicaid will continue to work on these efforts to address the opioid crisis and ensure Medicaid members have access to appropriate pain control and SUD treatment.

## AIM 2: Improved Quality of Care

NYS envisions a health care delivery system in which every Medicaid and CHPlus recipient has access to, and appropriately utilizes, high-quality, patient-centered care. Often marginalized and neglected, increased urgency is now being felt to improve the quality of care for both substance use disorder and opioid use disorder treatment. NYS has been profoundly affected by the opioid epidemic, which has only been exacerbated by the COVID-19 pandemic. As prevalence of SUD and OUD remain high, quality long-term treatment that is accessible and comprehensive is needed.

High-quality primary care can be more quickly realized with the promotion of Patient-Centered Medical Homes (PCMHs). As of December 2019, 2.9 million Medicaid recipients utilize primary care from a National Committee for Quality Assurance (NCQA) recognized PCMH. This achievement was made possible since the state invested money in Medicaid incentive payments for those primary care clinicians and practices that met the standard. NYS has developed its own enhanced, NYS-specific form of PCMH through NCQA as of 2018. The current goal is to expand access to PCMHs to all Medicaid and CHPlus recipients over the next several years.

Finally, attention must be paid to the health care workforce to ensure that providers are working to the full scope of their licenses. Programs that encourage physicians to provide primary care in rural areas of the state must be fostered and health plan provider networks need to be continually monitored to ensure they are robust and deliver ready access to high quality care.

## Goal 6: Improve Quality of Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) Treatment

Multiple literature reviews have concluded that SUD treatment in the United States has large gaps in quality of care. They highlight that available treatment is isolated from healthcare and too few people with SUD have access to the system. As such, there is an urgent need for strategies to improve SUD treatment quality via better connection to treatments, increased six-month treatment retention rates, increased use of pharmacotherapy, and improved recovery outcomes.

Since 2015, OASAS has been working closely with the NYSDOH to establish a practical yet adequate set of metrics that are also part of the NYS VBP initiative. The challenge faced at the time was there were few national measures of effectiveness or quality of substance use treatment that had been validated. OASAS worked with MCOs, providers, and the NYSDOH to more fully develop and implement several measures. Some of these new measures assess whether patients continue in care after inpatient discharge, the use of FDA-approved medications for MAT, and retention in care. The adherence and retention measures will be compared for opioid treatment program patients who attend at least 4 days a week and those provided at least weekly take-home doses. These measures have support in the literature and are process indicators that are correlated with outcomes.<sup>50</sup>

With the collaboration of the NYSDOH and the Behavioral Health VBP Clinical Advisory Group, efforts to promote these measures in all clinical settings continue. The data is shared with providers and plans to inform current performance and identify opportunities for improvement. OASAS has also been working with providers and provider networks on how to incorporate interventions and measures into quality improvement activities. This includes efforts underway through a National Institute on Drug Abuse (NIDA) grant which will provide resources and training for SUD providers to further aid in improving performance measures.

**Table 6:** Metrics, Baseline Rates and Target Rates for *Improve Quality of Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) Treatment (A2:G6)*

Metric	Baseline	Target
#14: Initiation of Pharmacotherapy upon New Episode of Opioid Dependence (POD-N)	38%	39%
#15: Initiation of alcohol and other drug dependence treatment (IET)	45%	46%
#16: Engagement of alcohol and other drug dependence treatment (IET)	20%	21%

## **Interventions**

### **Learning Collaboratives, Regulatory Changes, and Peer Linkages (CC, SDH)**

OASAS has several initiatives focused on improving treatment access to high-quality evidence-based treatment for OUD and other SUD. These include learning collaboratives for prescribing professionals to encourage increased access to buprenorphine-waivered professionals across the state; regulatory changes that require medication for OUD in all OASAS-certified settings; and peers to provide linkage between levels of care and to connect people directly to care from emergency rooms or high intensity care. The interventions chosen are shown to be effective in reaching goals that impact quality SUD treatment.<sup>51,52</sup>

### **Expansion of Take-home Methadone Dosing (CC, SDH)**

OASAS is also engaged with Opioid Treatment Providers (OTPs) to increase use of take-home dispensing of methadone in these programs consistent with federal guidelines. Currently, 68% of patients in OTPs attend services at the OTP at least four times a week, with many attending six to seven days a week. Providing weekly, bi-monthly, or monthly take home to patients who are stable will allow them to receive care in a more person-centered way, which should foster recovery and increase treatment retention.<sup>53</sup>

### **Goal 7: Promote Prevention with Access to High Quality Care**

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all New Yorkers. NYSDOH performs various oversight activities to help ensure MCOs have developed and maintain adequate access to the necessary types of providers in their networks. MCO provider networks must contain all of the provider types necessary to furnish the prepaid Benefit Package, including but not limited to: hospitals, physicians (primary care, which may include OB/GYNs, and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, durable medical equipment (DME) providers, home health providers, and pharmacies, if applicable. In addition to containing the necessary provider types, MCOs must comply with timely access requirements and appointment availability standards for: emergency/urgent care, urgent and non-urgent mental health and substance abuse care, routine well and preventive care for children and adults, non-urgent sick visits, non-urgent specialist visits, initial prenatal visits, and initial family planning visits.

On a quarterly basis, MCOs must submit updated information on their contracted provider network to NYSDOH. As part of the quarterly reports, MCOs provide information on the number of Medicaid enrollees empaneled to each network Primary Care Provider (PCP). In addition, any material change in network composition must be reported to the state 45 days prior to the change. Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turnover. MCOs also submit quarterly rosters for their network PCPs. The PCP is identified for every

managed care enrollee, which allows new analyses such as quality of care for enrollees in PCMHs versus those who are not.

NYS is committed to working towards eliminating the financial, geographic, cultural, and operational barriers that limit access to appropriate care in a timely manner. To achieve this end, NYS has invested in primary care delivery systems, after-hours care, telehealth and remote patient monitoring, transportation, and the health care practitioner and community health workforce. NYSDOH has several programs, surveys, and audits to evaluate MCOs and providers on 1) ensuring network adequacy; 2) reducing the number of prior authorizations; 3) ensuring there is timely access to care (including after-hours care); 4) providing access to telehealth and remote patient monitoring innovation; and 5) providing safe and reliable transportation services for Medicaid enrollees. NYSDOH also conducts several Medicaid member surveys to measure the perception of care and quality of life outcomes, as well as to monitor access to care and ensure that MCOs and providers are providing high-quality service in a timely manner to all individuals.

NYS has also invested in the NCQA PCMH model, which focuses on building stronger relationships between patients and their clinical care teams by putting patients at the center of care. The primary care provider is responsible for managing the individual's health care needs as well as coordinating with other clinicians in other settings when care cannot be provided in the primary care setting. Studies have shown that PCMH was associated with \$265 lower average annual total Medicare spend per beneficiary (4.9%), lower hospital spending and fewer ED visits (55 fewer visits per 1000 beneficiaries for all causes).<sup>55</sup>

The performance target for Metric #17 in Table 7 is set to 70% to account for an expected increase of 4% and reflect a 3% drop due to practices with recognition set to expire.

**Table 7:** Metrics, Baseline Rates and Target Rates for *Promote Prevention with Access to High Quality Care (A2:G7)*

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#17: MMC population impacted by Patient-Centered Medical Home (PCMH) sites of recognition 2014 level 3 and up- active	69%	70%

**Interventions**

**Patient Centered Medical Home (PCMH) (CC, SDH)**

The NCQA's PCMH recognition program has been the most widely adopted outpatient medical provider/practice evaluation program in the country since its initial release in 2008. Practices and their providers in NYS have been recognized under NCQA's 2011, 2014, or 2017 standards. On April 1, 2018, the NYSDOH released a customized PCMH recognition program

built upon the NCQA PCMH 2017 model. NYS PCMH supports the state's goal of improving primary care and promoting the Triple Aim. The program helps practices improve patient access and experience, perform comprehensive health assessments to identify patient needs, deliver preventive care such as immunizations and cancer screenings, prioritize comprehensive care management to control chronic conditions, coordinate with other clinicians to close referral gaps, and identify patients who require recommended interventions and patients who need medication monitoring. The program requires the transformation of care through meaningful use of HIT. In collaboration with the SHIN-NY, program participants can meet this requirement and use HIT techniques to achieve program goals.

As of December 2019, 8,189 (35%) of primary care physicians (PCPs) in Medicaid managed care (MMC) were recognized as a PCMH-recognized provider and over half (69%) of mainstream MMC, HARP, and HIV SNP enrollees were assigned to a PCMH-recognized PCP.<sup>56</sup>

### **Maximize Workforce Distribution**

While NY has an overall physician-to-population ratio that exceeds the national average, in most regions there is a maldistribution of physicians, both in terms of geographic location or availability of specialty services like primary care, obstetrics, general surgery, and child psychiatry. The maldistribution is reflected in 165 Primary Care Health Professional Shortage Areas in NYS, which requires over 1,000 primary care physicians to meet minimum physician access needs. More than 50% of NYS physician trainees leave the state after completing their training.

Supported by the Accreditation Council for Graduate Medical Education (ACGME) and the State Health Innovation Plan (SHIP)/DSRIP Workforce Workgroup, recommendations were implemented to commit to consistent funding for Doctors Across New York (DANY) to address workforce shortages with an annual cycle and predictable timeline for the application process, and an increase student exposure to rural and non-hospital settings through support of community rural training sites.

In the 2016-17 State budget, two DANY programs, Physician Loan Repayment and Physician Practice Support, were merged to simplify the programs and make them more efficient. 2020 marked the third consecutive annual funding cycle for DANY, timed to allow physicians completing residency to consider incentives for primary care and specialty positions in underserved areas as they make critical decisions about their careers.

Results of various elements of this initiative have been shared with various stakeholder groups: the Workforce Advisory Group; the State Innovation Model (SIM)/DSRIP Workforce Workgroup; and the Statewide Steering Committee. The Division of Workforce Transformation is implementing an evaluation program for DANY to assess if participants continue to practice in underserved areas after program completion.

## **Provider Wellness Survey**

Understanding clinician characteristics, including stress and whether it differentially impacts certain segments of the provider population, is an important facet in describing the current workforce and predicting trends. Measuring burnout among clinicians is important because clinician welfare and emotional well-being can have significant effects on workforce stability and quality of care.<sup>57</sup> Provider well-being may be especially impacted during times of excessive stress, such as a public health emergency or pandemic.

The Provider Wellness Survey seeks to both establish baseline levels of burnout among NYS providers and uncover how the COVID-19 pandemic has affected providers' self-reported stress, burnout, and job satisfaction. Additionally, the survey gauges the extent to which meeting regulatory reporting requirements for clinicians increases clinician burden and stress. Data will be shared between the NYSDOH's OQPS, New York Chapter of American College of Physicians (NYACP), and the Center for Health Workforce Studies (CHWS).

## **Community Health Workers (CC)**

The SHIP/DSRIP Workforce Workgroup Subcommittee on Barriers to Effective Care Coordination determined that the scope of practice for licensed professionals generally does not preclude them from carrying out tasks related to care coordination. However, the subcommittee identified Community Health Workers as an area in need of more in-depth discussion, with the expectation that promoting the use of Community Health Workers would increase knowledge about their services and improve utilization among health care providers and agencies.

The Workforce Workgroup presented a panel discussion on Community Health Workers, including a presentation by the chair of the National Association of Community Health Workers on the role and training of Community Health Workers. Also presenting were representatives of several best practice models of effective Community Health Worker utilization. This included the NYSDOH Office of Public Health (OPH) Bureau of Community Chronic Disease Prevention and the OPH Bureau of Women, Infant, and Adolescent Health. Staten Island PPS presented on their Community Health Worker training program that partners with the College of Staten Island and the New York City Housing Authority (NYCHA) to provide free training to NYCHA residents. Also partnering with an institute of higher education is Montefiore Community Health Worker Apprentice Program, which provides a two-year training program in coordination with Hostos Community College.

The Workforce Workgroup has established a Workforce Compendium and Resource Guide on the NYSDOH website: <https://www.health.ny.gov/professionals/compendium/>, to share information about Community Health Worker programs and other innovative workforce programs. Submissions for the Compendium are currently under review.



## **Network Adequacy**

Network adequacy analyses ensure that MCOs operating in NYS have an adequate number and variety of health care providers in their networks to provide appropriate access to care for their enrollees, which includes being geographically accessible (meeting time/distance standards based on geographic location), being accessible for the disabled, and promoting and ensuring the delivery of services in a culturally competent manner. Network adequacy standards are published in the Medicaid Managed Care and CHPlus model contracts and are posted on the NYSDOH webpage.

Health plans submit provider networks to the NYSDOH for analysis, which requires that there be sufficient numbers of providers in all service areas. A review is completed for each county and each type of provider, by plan. The results of each analysis are shared with the health plans on a quarterly basis, and reviews that failed to meet NYSDOH standards (“deficiencies”) are highlighted. Health plans are responsible for reviewing and addressing deficiencies, which includes expanding their provider networks to meet set standards. The process for submitting, analyzing, and discussing provider networks is done electronically on a web-based platform that allows plans to continuously update their network submission to the NYSDOH, streamlines ongoing monitoring of network adequacy, and allows NYSDOH to make up-to-date network data publicly available. Based on network data from October 2019, 82% of the provider adequacy reviews completed passed the State’s standards.

In the event the MCO does not have a provider in their network with appropriate training and experience to meet a particular health or behavioral health care need of an enrollee, or who does not have an available appointment, the MCO must make a referral to an appropriate out of network provider and must cover the service. MCOs must also allow for second opinions for diagnosis of a condition, treatment or surgical procedure by a qualified physician or appropriate specialist, including one affiliated with a specialty care center. In the event the MCO determines that it does not have a provider in its network with appropriate training and experience qualifying the provider to give a second opinion, the MCO must make a referral to an appropriate out of network provider and pay for the cost of the services associated with obtaining a second opinion provided by the out-of-network provider.

Provider networks are submitted to the NYSDOH at least quarterly. Using aggregated submissions, a third party performs reviews on each category of service in each plan’s active service area. The results of these reviews are aggregated and delivered to the NYSDOH. The NYSDOH will continue to assess the proportion of reviews that meet overall adequacy standards each quarter.

## **Telehealth and Remote Patient Monitoring Innovation**

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a Medicaid member. Pursuant to NYS PHL Article 29-G, as recently

amended in 2018 and Social Services Law Section 367-u, NYS Medicaid has expanded coverage of telehealth services to include:

1. Additional originating and distant sites;
2. Additional telehealth applications (store-and-forward telemedicine and remote patient monitoring); and,
3. Additional practitioner types.

CHPlus MCOs are responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc and 2999-dd of the Public Health Law and any implementing regulations.

- Telemedicine uses two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site.
- Store-and-forward involves the asynchronous, electronic transmission of a member's health information in the form of patient-specific, pre-recorded videos and/or digital images from a provider at an originating site to a telehealth provider at a distant site.
- Remote patient monitoring uses digital technologies to collect medical data and other personal health information from members in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations. Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, weight, blood sugar, blood oxygen levels, and electrocardiogram readings.

### **Provide Safe, Reliable Transportation (SDH)**

The NYSDOH contracts with two professional transportation managers across 5 geographic regions to administer Medicaid's transportation benefit. ModivCare and MAS deliver transportation services to both FFS and MMC covered enrollees. The goal of these managers is to secure the most medically appropriate, cost-effective level of transportation so enrollees may safely access their Medicaid-covered services.

Managers interact daily with enrollees, medical providers, and transportation providers to facilitate provision of this benefit. Regional field liaison staff dedicated to specialized regions are available for training and in-services on transportation. The Department holds annual, regional stakeholder meetings to keep all groups informed on any transportation updates and to address any challenges. Effective statewide as of October 2020, all standing orders (recurring trips to the same location) must be submitted electronically by the medical provider through the transportation manager's online portal. Currently, one of the managers uses an electronic version of the Medical Justification form with real-time decision making enabled and both managers are working on electronic submission for New York State's Common Medical Market area.

## **Performance Improvement Projects (PIPs) (CC)**

MMC plans, including HARPs, 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: Perinatal Care and The Kids Quality Agenda PIP, and for HARP: Inpatient Care Transitions and HARP: Care Transitions after Emergency Department and Inpatient Admissions.

The 2019-2021 Kids Quality Agenda PIP was previously discussed under **Goal 2: Ensure a Healthy Start.**

The 2019-2021 HARP PIP focus is on Care Transitions after Emergency Department and Inpatient Admissions. The aim of the PIP is to facilitate successful transition for HARP and HIV SNP members after ED visits and inpatient mental health care to community care and from inpatient SUD detoxification or inpatient SUD rehabilitation to a lower level of care, and to reduce subsequent ED visits and inpatient readmissions by:

- Identifying and improving weaknesses in discharge planning processes and achieving a comprehensive, patient-centered discharge plan, including needed post-discharge follow-up, community supports, and medication reconciliation;
- Facilitating communication and coordination among the ED providers, inpatient providers, community providers, the member, Health Homes, and HARP/HIV SNP case management; and,
- Initiating medication and ensuring medication adherence (such as medication-assisted treatment (MAT) for SUD members and clozapine initiation for Mental Health members).

PIP processes and results are presented in final reports and are due seven months after each study concludes. Webinars are held throughout the collaborative PIP projects, in which participating health plans are brought together to discuss lessons learned and describe individual experiences with these quality improvement projects.

MLTC plans also conduct PIPs on a yearly basis. MLTC PIPs focus on clinical and non-clinical areas consistent with the requirements of 42 CFR 438.240 of the Medicaid model contract. One priority project is chosen for each 2-year period and approved by the NYSDOH. PIP topics for 2019-2021 include:

- Transitions of Care, and
- Emergency Department/Hospitalization Reduction,

Older adults with chronic illness frequently require care from different practitioners in multiple settings. Many of these members have limited ability to navigate an increasingly complicated care delivery system. The ED frequently becomes the focal point in the health care system when care is poorly coordinated. Access to healthcare through the ED presents an avenue for people not necessarily suffering from the life- and limb-threatening conditions such departments are designed to address. Overuse leads to needless expense, crowding, and reductions in access to those in true need. Patients often seek care in the ED instead of in a more appropriate care setting for their condition.<sup>58</sup>

Specific inpatient hospitalizations are considered potentially avoidable. Diagnoses of respiratory infection, urinary tract infection, and congestive heart failure are examples of potentially avoidable hospitalizations. Had outpatient services been provided in a timely manner, these hospitalizations may have been prevented. These episodes of care can have serious effects on MLTC members and families and are barriers to the overall goal of the MLTC program.

MLTC PIPs strive to improve the health and health care of the aged and disabled adult populations. Interventions in past PIPs have included:

- Increased data mining of health assessment data;
- Increased care coordination;
- Development of multidisciplinary teams to address PIPs within the health plan;
- Increased home care visits; and,
- Member, provider, and care manager education through classes and the creation of educational materials.

### **Focused Clinical Studies**

Focused clinical studies, conducted by the External Quality Review Organization (EQRO), usually involve medical record review, measure development, surveys, and/or focus groups. MCOs are typically required to participate in one focused clinical study a year. Studies are often population specific (MMC/HIV SNP, MLTC, HARP). Upon completion, the EQRO provides recommendations for improvement to the NYSDOH, plans, and/or providers. Past studies have addressed frailty indices, the provision of advanced directives, functional assessment inter-rater reliability, validation of vital statistics reporting, use of developmental screening tools, care transitions, and provision of prenatal care.

### **Goal 8: Support Members in Their Communities**

NYS has been actively working towards ensuring children and adults have access to high-quality care which keep individuals in the least restrictive settings regardless of payer, age, or disability. NYS has several initiatives addressing keeping members in their community including Medicaid's Managed Long Term Care program, 1915(c) Children's Waiver (formerly the "Care at Home Waivers 1 & 2"), home and community-based services, Money Follows the Person

demonstration, Consumer Directed Personal Assistance Program (CDPAP), and the Nursing Home Transition and Diversion waiver.

For children specifically, NYS has historically used the Care at Home (CAH) waiver programs to provide case management for a variety of services, therapies, and medical care for children with developmental disabilities and/or complex medical conditions. Historically, the CAH waivers were administered by NYS and OPWDD with the CAH Waivers I and II directed by the NYSDOH. The CAH Waiver terminated on March 31, 2019. As of April 1, 2019, a new 1915 (c) Children's Waiver operated by the NYSDOH was established. Children currently enrolled in one of the six 1915(c) waivers began to transition to Health Homes Serving Children over the course of the waiver period.

The 1915(c) Children's Waiver helps keep children with their families in the community by streamlining administration; making eligibility processes and benefits consistent across all populations; providing Health Home care management to children; and authorizing family peer, youth peer, and crisis intervention to HCBS-eligible children. Over a three-year period, the Children's Waiver will also increase cost-effective quality care to children by eliminating the use of waiting lists related to HCBS capacity under the waiver.

The Money Follows the Person (MFP) Demonstration is part of Federal and State initiatives designed to increase the use of home and community-based services and reduce the use of institutionally based services. This program focuses on the dignity and autonomy of individuals enrolled in Medicaid by promoting choice, enhancing quality of life, and expanding options for community-based care delivered in the least restrictive setting. MFP also strives to eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds for home and community-based services; strengthen the ability of Medicaid programs to provide home and community-based services to people who choose to transition out of institutions; and support procedures to provide quality assurance and improvement of home and community-based services. As of 2016, over 1,500 New Yorkers have successfully transitioned via NYS's MFP Demonstration.

The Consumer Direct Personal Assistance Program (CDPAP) is a Medicaid program that provides service to self-directing chronically ill or physically disabled individuals (or those with a self-directing legal guardian) who have a medical need for help with activities of daily living or a need for skilled nursing services. This program preserves individual quality of life by allowing the individual to choose their caregiver and hiring, training, supervising, and if needed, terminating the person providing the care.

These programs empower individuals to live their lives in the setting they choose and generally decreases the cost of care, which is historically higher when delivered in an institutional setting. The national average monthly per capita cost of serving a MFP participant in the community was \$3,609 in 2015.<sup>59,60</sup> In comparison, the national average cost of a semi-private room in a

skilled nursing facility was \$6,692 per month in 2015.<sup>61</sup> Furthermore, Mathematica’s comprehensive evaluation for CMS shows that participants experience positive increases across all seven domains of quality of life after transitioning to the community, and the improvements are largely sustained two years post-transition.<sup>62</sup> NYS is committed to preserving the autonomy, dignity, and community engagement for individuals regardless of their payer type or diagnosis, as well as ensuring the quality of care provided in community-based settings.

**Table 8:** Metrics, Baseline Rates and Target Rates for *Support Members in Their Communities (A2:G8)*

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#18: Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection.	2.76	2.70
#19: Percentage of members who rated the helpfulness of the plan in assisting them and their family to manage their illnesses about their plan of care	86.0	87.0

## **Interventions**

### **Support Palliative Care Models (CC)**

For Medicaid members with diseases in more advanced stages, Palliative Care initiatives focus on improving quality of life. Palliative Care recognizes the symptoms and stress of the disease and its treatment, entailing a broad range of issues that can include pain, depression, anxiety, feeling “at peace,” and loss of appetite, as well as addressing advance directives. At the advanced end of the spectrum, Hospice Care moves away from “cure” to comprehensive comfort care for the individual and support for the family. Hospice care can be delivered in the home, assisted living, nursing home, or inpatient setting.

Increasing access to palliative care programs and hospice for persons with serious illnesses and life-threatening conditions can help ensure care and end-of-life planning needs are understood, addressed, and met prior to decisions to seek further aggressive care. Two promising practices<sup>63</sup> in NYS have emerged from the Medicaid Reform efforts that warrant broader replication and scale:

- Palliative Care introduced in primary care settings through the PCMH model; and,
- Palliative Care administered through nursing homes.

Much education on the role of palliative care and the distinction of palliative care and hospice care still is needed for health care practitioners, as well as with Medicaid members and their

families. These efforts will support palliative care programs already in place in many larger hospitals where care plan decisions can be made and where appropriate post-discharge care planning can be done.

In the 1115 Waiver Reform program, the Integrated Palliative Care Outcomes Scale<sup>64</sup> (IPOS) was used. This tool was selected **to measure access to palliative care services** for patients most in need, **not** to evaluate the outcomes associated with palliative care interventions. Five measures were included in the evaluation of this project:

- 1) Percentage of patients indicating need who were offered or provided an intervention for pain symptoms experienced during the past week;
- 2) Percentage of patients indicating need who were offered or provided an intervention for physical symptoms other than pain experienced during the past week;
- 3) Percentage of patients indicating need who were offered or provided an intervention for **not** feeling at peace during the past week;
- 4) Percentage of patients indicating need who were offered or provided an intervention for depressive feelings experienced during the past week; and
- 5) Percentage of patients indicating need who were offered or provided an intervention when there was no advance directive in place.

Preliminary qualitative findings by the Independent Evaluator show that PPS partner survey respondents saw IPOS implementation as a means to improve the quality of palliative care.<sup>22</sup>

### **Home and Community Based Services (CC, SDH)**

Home and Community Based Services (HCBS) are designed to allow enrollees to participate in a vast array of habilitative services. They are based on the idea that state services, programs, and activities should be administered in the most integrated and least restrictive setting appropriate to a person's needs. HCBS services include Managed Long-Term Care Services and Supports, Care Coordination, Skill Building, Family and Caregiver Support Services, Crisis and Planned Respite, Prevocational Services, Supported Employment Services, Community Advocacy and Support, Youth Support and Training, Non-Medical Transportation, Habilitation, Adaptive and Assistive Equipment, Accessibility Modifications, and Palliative Care. HCBS are available to Medicaid members who meet specific qualifications, through Medicaid waiver programs, the Community First Choice Option (CFCO) initiative, and HARPs. HCBS services are designed to help individuals achieve goals and be more involved in their community.

HCBS are offered under a wide variety of programs across NYS agencies. They currently include:

### **MLTC**

Long-Term Services and Supports have always been part of the Medicaid benefit package. They include services and supports used by enrollees with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing,



preparing meals, and administering medications. Such services may be provided at the home, in the community, or in institutional settings. They were implemented for enrollees to live safely in the most integrated and least restrictive setting.

MLTC plans provide health and long-term care services to keep eligible individuals healthy and living in the community. There are three types of MLTC plans: Partial Capitation, Program of All-inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus (MAP). Each plan covers the same base set of services, with certain plans covering additional services. Support for the need for Long-Term Services and Supports is underscored by the increasing age of the Medicaid population and the steadily increasing enrollment in MLTC plans. MLTC enrollment has steadily increased over the past fourteen years from approximately 10,000 in 2004 to over 282,472 as of January 2022. 83.6% of those enrolled in MLTC plans are 65 years of age or older. The increase in enrollment in MLTC plans has accelerated following the implementation of Medicaid Redesign Team (MRT) #90, which is a MRT effort that entailed the mandatory transition and enrollment of certain community-based long-term care services recipients into Managed Long-Term Care as a component of a fully integrated care management system. In August 2012, the NYSDOH received written approval from CMS to begin mandatory enrollment in MLTC. This amendment to the Partnership Plan Medicaid Section 1115 Demonstration waiver required all dual-eligible individuals (persons in receipt of both Medicare and Medicaid benefits) age 21 or older and in need of community-based long-term care services for more than 120 days to be mandatorily enrolled into Managed Long-Term Care Plans. The transition to MLTC was implemented in five phases ending in 2014. The following groups were excluded from this transition to MLTC:

- Nursing Home Transition and Diversion Waiver participants;
- Traumatic Brain Injury Waiver participants;
- Assisted Living Program participants; and
- Dual-eligible individuals who do not require community-based long-term care services.

In 2021, New York State implemented a change to disenroll from the Partial Capitation MLTC plans those enrollees who are long stay nursing home residents, unless they are working toward return to the community.

NYSDOH oversight includes evaluating quality of care delivered by MLTC plans. MLTC plans are required to collect and report information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then annually thereafter, via the UAS-NY Community Health Assessment instrument, which may include a Functional Supplement and/or Mental Health Supplement. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community-based programs in NYS.

Following submission of UAS-NY data, the NYSDOH creates summary reports containing descriptive information about members' status. The quality performance component of these

reports is divided into two sections: 1) Current plan performance – Functional status and rates of performance based on the current submission and 2) Performance over time – Changes in the functional status of the MLTC population over 12-month period.

One of the primary objectives of long-term care is to improve or stabilize functional status, with stabilization being the most likely outcome for this population. For this reason, positive outcomes for most items are defined as either a member showing improvement over the measurement period or maintaining his/her initial level of functioning/ symptoms. Domains of measurement include:

- Activities of Daily Living;
- Quality of Life;
- Effectiveness of Care;
- Emergency Room Visits; and,
- Utilization and Patient Safety.

### ***Health and Recovery Plans (HARP)***

In addition to the benefits covered under Mainstream Medicaid Managed Care, HARP enrollees also have access to two groups of benefits under the 1115 Demonstration Waiver: Adult Behavioral Health Home and Community Based Services (BH HCBS) and Community Oriented Recovery and Empowerment (CORE) Services. Adult BH HCBS includes the following services: Habilitation, Education Support Services, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment. CORE includes the following services: Psychosocial Rehabilitation, Community Psychiatric Support and Treatment (CPST), Family Support and Training, and Empowerment Services – Peer Support.

### ***Traumatic Brain Injury (TBI) Waiver***

**The Traumatic Brain Injury (TBI)** program is a 1915 (C) Medicaid waiver that provides a continuum of services to Medicaid eligible individuals who are between the ages of 18-64 upon application, diagnosed with a traumatic brain injury, assessed to need nursing home level of care and are residing or are able to reside in the community with the support of waiver services. TBI waiver services are used to complement available Medicaid and community supports and services. A description of eligibility requirements and available services is available at:

[https://www.health.ny.gov/health\\_care/medicaid/program/longterm/tbi.htm](https://www.health.ny.gov/health_care/medicaid/program/longterm/tbi.htm)

### ***Nursing Home Transition & Diversion Waiver***

**The Nursing Home Transition and Diversion (NHTD)** program is a 1915 (C) Medicaid waiver that provides a continuum of services to Medicaid eligible individuals who are physically

disabled or are age 65 or older, assessed to need nursing home level of care and are residing or are able to reside in the community with the support of waiver services. NHTD services are used to complement already available Medicaid and community supports and services. A description of eligibility requirements and available services is available at: [https://www.health.ny.gov/facilities/long\\_term\\_care/nhtd/](https://www.health.ny.gov/facilities/long_term_care/nhtd/)

### ***Community First Choice Option (CFCO)***

This program is being phased in and includes the following HCBS: Assistive Technology; Activities of Daily Living and Instrumental Activities of Daily Living skill acquisition, maintenance, and enhancement; Community Transitional Services; Moving Assistance; Environmental Modifications; Vehicle Modifications; and Non-Emergency Transportation.

**Children's Home and Community Based Services:** This inter-agency program consolidates multiple 1915(c) children's waiver programs from different agencies, including:

- DOH Care at Home waivers for children with physical disabilities;
- OMH Waiver for Children and Adolescents with Serious Emotional Disturbance;
- OPWDD Care at Home waiver; and,
- OCFS Bridges to Health SED waiver, B2H Developmental Disability (DD) waiver, and B2H Medically Fragile waiver

This children's program is being slowly phased in and includes the following HCBS: Community Habilitation, Day Habilitation, Caregiver/Family Supports and Services, Respite, Prevocational Services, Supported Employment, Community Self-Advocacy Training and Supports, Non-Medical Transportation, Adaptive and Assistive Equipment, Vehicle Modifications, Environmental Modifications, Palliative Care – Expressive Therapy, Palliative Care – Massage Therapy, Palliative Care – Bereavement Service, Palliative Care – Pain and Symptom Management, Family Peer Supports Services, Youth Peer Supports, and Crisis Intervention.

While not all programs have a developed quality/evaluation strategy with quality measures, MLTC and HARP have a program evaluation strategy. For HCBS in MLTC, the HCBS-related quality measures include the member satisfaction, survey-based quality measures mentioned earlier. For HCBS in HARP, plans are asked to follow Medicaid specifications in HEDIS /QARR NYS-specific measures. HARP HCBS-related quality measures include some NYS-Specific Behavioral Health Measures. These measures will be calculated and reported by NYS using the NYS Community Mental Health Eligibility Assessment (HARP members are required to be assessed for BH HCBS eligibility using the NYS Community Mental Health Eligibility Assessment at the time of enrollment and at least annually thereafter).

### **Goal 9: Improve Patient Safety**

In 1999, IOM issued its initial report, "To Err is Human," concerning the problem of preventable harm in medicine.<sup>65</sup> At the time, it was estimated that between 44,000 and 98,000 people died in

hospitals each year from medical errors. The report defined medical errors as the failure of a planned action to be completed as intended, or the use of a wrong approach to achieve an aim. This report described the associated cost in terms of lives lost, the expense of additional care necessitated by these errors, lost income and productivity, disability, and loss of trust in the health care system. The focus was on the inpatient setting, where high error rates with serious consequences were most likely to occur, in intensive care units, operating rooms, and emergency departments. Although the studies in the IOM report were performed many years before its issuance, “To Err is Human” had a profound effect because it measured for the first time the impact of medical errors at the national level.<sup>66</sup>

In the years since “To Err is Human” was released, interest in and measurement of patient safety has advanced in many important ways; however, the work to make care safer for patients has progressed at a much slower rate than expected.<sup>67</sup> While “To Err is Human” focused interest and efforts on patient safety, the expectation at the time was that expanded data sharing and implementation of interventions would result in substantial, permanent improvement. However, in the intervening years, it has become evident that safety issues are far more complex than initially identified. Furthermore, as the National Patient Safety Foundation (NPSF) stresses, patient safety encompasses more than just mortality; it also includes morbidity, disability, and other more subtle forms of harm, such as the loss of dignity and respect. It involves more than just inpatient care; it is a concern in every setting, from ambulatory clinics to long-term care facilities, to patients’ homes.

As stated by the NPSF, patient safety is more than inpatient safety, and while most efforts have centered on this area of the healthcare system, the NYSDOH is investing in initiatives across the care continuum.

**Table 9:** Metrics, Baseline Rates and Target Rates for *Improve Patient Safety (A2:G9)*

Metric	Baseline	Target
#20: Appropriate Treatment for Upper Respiratory Infections (URI) <ul style="list-style-type: none"> <li>• Children (3 months to 17 years)</li> <li>• Adults (18-64 years)</li> </ul>	94  72	95  74

## **Interventions**

### **Appropriate Antibiotic Use in Outpatient Healthcare**

Improving appropriate use of antibiotics in outpatient healthcare settings has been targeted as part of NYSDOH efforts to combat antibiotic resistance. Analysis of NYS Medicaid claims data for calendar year 2013 showed that 45% of adult patients seen in outpatient settings for acute respiratory tract infections, for which an antibiotic is not usually indicated, filled a prescription for an antibiotic following the visit.

The NYSDOH *Be Antibiotics Aware* campaign used this data to drive improvement in outpatient settings through targeted outreach to healthcare providers, development of clinician resources to support appropriate use of antibiotics, presentation of the data to clinicians to demonstrate the need for improvement, and the development of educational materials for patients. Additionally, collaborative efforts with stakeholders have helped promote the goal to reduce inappropriate antibiotic use. For example, coordination between the *Be Antibiotics Aware* campaign and NYSDOH led to development of healthcare provider education modules on antibiotic resistance and appropriate prescribing of antibiotics for upper respiratory conditions.

Measurement of appropriate use of antibiotics has been done using outpatient Medicaid claims and pharmacy data to assess antibiotic prescribing for acute upper respiratory infections (URI). Analyses identified a decrease in antibiotic prescribing over time, both among adult (18 and older) and pediatric (3 months to 17 years old) populations. Fewer adults who were seen for acute URI had antibiotics prescribed in 2017 (37.4 per 100 visits) when compared to 2010 (46.5 per 100 visits). Over 12,000 fewer visits for acute URI had an antibiotic prescribed in 2017 than in 2010.

Overall antibiotic prescribing for children with acute URI is lower than for adults. Similar decreases were noted in antibiotic prescribing for acute URI, with fewer children receiving an antibiotic when visiting the doctor for acute URI in 2017 (10.1 per 100 visits) than in 2010 (15.1 per 100 visits). The rates of potentially avoidable antibiotic prescribing are mapped by the county of visit after adjusting for differences in age, principal diagnosis (acute bronchitis vs. cold/acute URI), and visit type (emergency department, institutional outpatient, professional outpatient).

Ongoing analyses of Medicaid claims and pharmacy data include separate analysis of antibiotic prescribing for acute URI in pediatric and adult populations. Prescribing rates over time for each population by county of healthcare visit, in both tabular and map formats, have been made publicly available on the [HealthDataNY](#) website. Data are prepared and presented by county to provide local data for local action. Data is shared through broad public health messaging and direct presentation upon request of stakeholders.

### **Direct HealthDataNY links:**

Adult: <https://health.data.ny.gov/Health/Potentially-Avoidable-Antibiotic-Prescribing-Rates/vg7a-h5ss>

Children: <https://health.data.ny.gov/Health/Potentially-Avoidable-Antibiotic-Prescribing-Rates/r2m7-fr63>

### **Reducing Sepsis**

Severe sepsis and septic shock impact approximately 50,000 patients in NYS each year, and on average, almost 30% of patients will die from this syndrome. The NYS Sepsis Care Improvement Initiative has been a resource for quality improvement in sepsis care with the goal to improve early detection, timely interventions, and reduce overall mortality. Beginning in 2014, each acute care hospital in NYS that provides care to patients with sepsis was required by amendment of Title 10 of the New York State Codes, Rules and Regulations (Sections 405.2 and 405.4) to develop and implement evidence-informed sepsis protocols which describe their approach to both early recognition and treatment of sepsis patients. In addition, hospitals were required to report to the NYSDOH sufficient clinical data to calculate each hospital's performance on key measures of early treatment and protocol use. Each hospital submits clinical information on each patient with severe sepsis and/or septic shock to allow the NYSDOH to develop a methodology to evaluate risk-adjusted mortality rates for each hospital. Risk adjustment permits comparison of hospital performance and takes into consideration the different mix of demographic and comorbidity attributes, including sepsis severity, of patients cared for within each hospital.

The NYSDOH shares quarterly data with hospitals and publishes an annual public report highlighting hospital performance for each year. The annual public report includes risk-adjusted mortality rates for each hospital in NYS. The report is published annually on the NYSDOH's Sepsis Care Improvement webpage: <https://www.health.ny.gov/diseases/conditions/sepsis/>.

### **Breast Cancer Selective Contracting**

Every year, more than two thousand Medicaid enrollees undergo surgery for the treatment of invasive breast cancer. A vast body of literature has demonstrated a strong, positive association between surgical volume and improved outcomes and survival rates. Additionally, research conducted by the NYSDOH demonstrated improved five-year survival for patients receiving breast cancer surgery at high-volume facilities. Based on these findings, and to ensure high quality health care for Medicaid enrollees, the Medicaid Breast Cancer Selective Contracting (MBCSC) policy was implemented in 2009 and mandates that Medicaid enrollees receive breast cancer surgery, i.e., mastectomy and lumpectomy procedures associated with a primary diagnosis of breast cancer, at high-volume hospital and ambulatory surgery centers.

The MBCSC policy categorizes hospitals and ambulatory surgery centers, from here on referred to as "facilities" into one of three mutually exclusive categories annually: High-Volume (an

annual average of 30 or more surgeries performed over a three-year, rolling period), Low-Volume (an annual average of fewer than 30 surgeries performed over a three-year, rolling period), and Low-Allow. Low-Allow are low-volume facilities that have an annual average of fewer than 30 surgeries, but are permitted to perform surgeries, for one or more of the following reasons: *accessibility*, as restricting the facility would pose an unnecessary hardship on Medicaid enrollees; *experience/volume*, where facility volume is trending upward; *expanded surgical staff*, where one or more surgeon(s) were recently hired; and, *changes in the regional delivery system*, such as mergers or the closing of a local hospital. The MBCSC policy prohibits Medicaid FFS payment for breast cancer surgeries performed at Low-Volume facilities and stipulates that MMC plans must contract exclusively with approved facilities for breast cancer surgeries. The policy, and therefore this study, does not apply to dually eligible individuals (those insured by Medicaid and Medicare) as Medicare is the primary payer for these surgeries.

### AIM 3: Lower Per Capita Cost

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The 3<sup>rd</sup> guiding principle of the Triple Aim, critical in driving increased value in the NYS's Medicaid program and across individual health systems contracting with and serving NYS Medicaid's population, is to lower providers' per capita cost by increasing support for initiatives that drive higher value care and by adopting the alternative payment models that can support and sustain them.

In NYS, higher value care continues to be achieved by supporting evidence-based upstream and prevention-focused initiatives, continuing to increase resources for primary care providers, decreasing avoidable complications and readmissions, and by securing care coordination as a central lynchpin that fosters improved care integration and collaborative practices.

$\text{Efficiency}(\text{cost})/\text{Quality}(\text{outcomes}) = \text{Value}$
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Changing the way the “new” system delivers care, however, wouldn't be possible without changing the payment methodology and structure of payment, and NYS Medicaid continues to pave the way by increasing the adoption of value-based payment arrangements, alternative payment models, and sustainability of its quality incentive programs.

To support internal alignment with the 3<sup>rd</sup> Aim, critical internal fiscal controls help keep NYS Medicaid on a path toward success. Any new expenditures must be analyzed to assess their impact on both cost and quality, prior to approval and implementation. This level of internal scrutiny also remains critical in lowering per capita cost for the program as a whole and is supported by a global spending cap which helps drive savings for state taxpayers and the federal government. It represents the core of the state's budget neutrality argument for any future 1115 Medicaid waiver or state-directed payment template mechanisms employed.



To truly lower costs and improve quality, NYS must also continue to improve the overall efficiency of its health care safety net system by increasing the availability of resources for CBOs and by fostering inclusion of the critical work CBOs perform in the total cost of care. The Medicaid program continues to work hard to evolve CBO participation in the delivery system, given the proven efficacy non-profits provide to members across a variety of communities, statewide.

### Goal 10: Pay for High-Value Care

NYS is committed to improving outcomes for patients and populations by investing in innovative and sustainable delivery systems. Historically, the delivery system for the majority of Medicaid payments was based on FFS where providers were paid for the volume of services provided with limited quality measures affecting payment. In this former payment model, incentives for payments did not align with cost-effective high-value care including more time-intensive primary and preventive care.

NYS has worked to reform volume-based payment models through MMC, the DSRIP reforms, quality measurements tied to payments, and value-based payments, which all aim to organize a fragmented delivery system and integrate care provided to members to improve outcomes. Paying for value and reducing avoidable services will help to allow NYS to remain under the Medicaid Global Spending Cap without restricting eligibility, strengthen the financial viability of safety net providers, and support innovative and integrated delivery systems for care that will improve health outcomes for all New Yorkers.

The goal of VBP is to create the proper framework for providers to deliver high quality, integrated, patient-centered care at a reasonable cost. To ensure the long-term sustainability of the innovations and advancements from the DSRIP program, the State, along with stakeholders, created a VBP Roadmap for comprehensive Medicaid Payment Reform to which NYS committed to shifting 80-90% of MMC dollars into value-based payment contracts, which was approved by CMS.<sup>69</sup> In order to track progress towards the goal of “paying for high value care,” the NYSDOH utilizes the 3M Potentially Preventable Admission (PPA) methodology. The 3M PPA methodology identifies hospital admissions that could potentially have been preventable with better coordinated care or dealt with in the outpatient setting. These hospital admissions may result from hospital and/or ambulatory care inefficiency, lack of adequate access to outpatient care, or inadequate coordination of ambulatory care services.<sup>70</sup> Table 10 describes the four metrics that the NYSDOH will be monitoring to determine whether the interventions listed below are making an impact towards progress of this goal. The baseline year utilized below is CY 2019. The target range has been calculated using a +/- 2.5% of the 2019 rate. This +/- 2.5% is consistent with how NYSDOH is measuring/monitoring other metrics.

**Table 10:** Metrics, Baseline Rates and Target Rates for *Pay for High-Value Care* (A3:G10)

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
#21: Potentially Preventable Admissions per 100,000 members (MMC only*)	1,153	1,124 - 1,181
#22: Potentially Preventable Admission Expenditures / Total Inpatient Expenditures (MMC only*)	9.97%	7.47 - 12.47%
#23: Potentially Preventable Admissions per 100,000 members (FFS and MMC**)	1,097	1,069 - 1,124
#24: Potentially Preventable Admission Expenditures / Total Inpatient Expenditures (FFS and MMC**)	10.33%	7.83 – 12.83%

\* MMC only is the VBP eligible population which includes individuals enrolled in a managed care plan on 12/31 of respective year, excluding FFS, dual eligible and third party\*\* MMC and FFS are individuals with FFS coverage or enrolled in a managed care plan on 12/31 of respective year, excluding dual eligible and third party.

## **Interventions**

### **Medicaid Reform and the Move to Value-based Payments (CC, SDH)**

On April 14, 2014, NYS and CMS reached agreement on a groundbreaking 1115 Medicaid waiver that allowed the State to invest \$8 billion of the \$17.1 billion in federal savings generated by the MRT reforms for comprehensive Medicaid delivery and payment reform. Since its approval by CMS, the State transformation has provided incentives for Medicaid providers to create and sustain an integrated, high-performing health care delivery system that could effectively and efficiently meet the needs of Medicaid members in their local communities by improving the quality of care, improving the health of populations, and reducing costs. This effort also represented the first step in NYS's transition to VBP, which set a trajectory for a continued advance toward value-based care.

This transformation promoted community level collaboration and sought to reduce avoidable hospital use by 25 percent over the five-year demonstration period, while financially stabilizing the State's safety net providers.<sup>71</sup> Twenty-five PPSs were established statewide to implement innovative projects across three domains: system transformation, clinical improvement, and

population health improvement (NYS's Prevention Agenda). Funding was awarded to PPSs based on achievement of performance goals and project milestones.

Through the innovative efforts of the 25 PPSs and their partners, NYS has achieved significant reductions in measures of avoidable hospital use including, *Potentially Preventable Admissions* and *Potentially Preventable Readmissions*.<sup>22</sup> The combined reductions are estimated to have reduced per member per year preventable costs over the five years of the demonstration.<sup>22</sup> Additionally, preliminary results of the Independent Evaluation show all measures of primary care, timely access, care transitions, and system integration improved; the majority of the DSRIP program measures of health care service delivery integration and health care coordination improved; and PCMH achievement increased.<sup>22</sup>

As a result of this work, integrated delivery networks have developed, strengthened, and matured over the waiver period to collectively improve performance in both quality and cost-savings. These new networks have advanced never-before-tested service models and have had the shared experience of meaningful collaboration to exceed performance targets and earn performance dollars. By doing so, these networks have been able to further participate in innovative VBP arrangements. In just a few years, NYS has significantly moved its Medicaid program from almost exclusively FFS to primarily value-based payment strategies.

Today, at least 86% of NYS's MMC expenditures are contracted under a VBP model, and at least 56% are contracted in risk bearing arrangements where providers share in financial risk for cost and quality outcomes. NYS was the first state in the nation to require certain VBP arrangements to include SDH interventions and contractual agreements with one or more CBOs. Every VBP risk arrangement (56% of MMC expenditure) has a defined SDH intervention and includes community-based human and social services organizations.

The NYS VBP Roadmap has defined the State's VBP model to standardize and guide various components of the State's approach to payment reform that incorporates both cost (efficiency) and quality incentive rewards based on performance. The Roadmap accounts for both fully capitated and partially capitated products which cover Mainstream Medicaid, HARP, HIV SNPs and MLTC. The VBP model for MLTC was slightly modified from the non-MLTC product lines to account for the intricacies of a dual-payor (Medicaid/Medicare) service delivery model.

In both Mainstream and MLTC, the VBP model seeks to reward MCOs and providers when care is transitioned to more appropriate, and often lower cost settings and when quality outcomes improve. To support a whole-person approach to care delivery, future payment models should incorporate social context into payment, performance, and care delivery, supported by evolving data-sharing standards, and stronger network integration. The transition of care to more appropriate settings, improved quality outcomes, better patient experience, and a whole-person approach to care delivery supported by integrated networks also remain the underlying goals of payment reform.

As the transition to VBP evolves and matures, the NYS Medicaid Program will seek to identify and refine new and existing quality measures and payment arrangements that reflect individual and population health outcomes that are inclusive of SDH. Throughout the transition, provider networks should continue to align promising practices and service delivery methods; develop shared governance; and streamline processes, data systems, and quality measures, to meet the unique needs of Medicaid members across the care continuum. Providers and MCOs must work together to refine data exchange strategies, identify opportunities for lowering per capita cost, explore for and taking on risk-based arrangements, and develop models of care integration. Finally, MCOs and providers need time to structure VBP arrangements so that the most impactful evidence-based and promising performance-based practices can be leveraged and sustained.

### **Value-based Payments Core Measurement Strategy**

The goal of payment reform is to drive changes in paying health care providers for the quality of the care they render, instead of the quantity of care. Measure requirements are often not aligned among payers, which has resulted in confusion and complexity for reporting. NYS embarked on a core measure set strategy in 2018 which identifies the highest priorities for quality measurement and improvement and provides alignment with other national measurement sets such as the Merit-based Incentive Payment System (MIPS).

The development of this core measure strategy involved a stepwise approach: 1) gathering stakeholder feedback on current quality measure landscape, 2) developing and instituting an annual quality measure review cycle, 3) assessing current contracting practices, 4) developing and recommending policies to address the gaps in core measurement strategy, 5) aligning quality measures across programs where feasible, and 6) developing a program-level framework to monitor the achievement of results and to adjust relevant programs, policies, and activities when necessary.

### **Promote Data Sharing via the Statewide Health Information Network for New York (SHIN-NY)**

The SHIN-NY is viewed as a bedrock component that is essential to support NYS's broader health care goals with respect to improving the quality and efficiency of health care for all New Yorkers. Other aspects of the technical infrastructure include electronic health records and personal health records, and clinical informatics services which refer to the tools required for the aggregation, analysis, decision support and reporting of data for various quality and public health purposes. The SHIN-NY "information highway" allows clinicians and consumers to make timely, fact-based decisions that can reduce medical errors, reduce redundant testing, and improve care coordination and quality. The successful implementation of the SHIN-NY is one of the drivers improving health care quality, reducing costs, and improving outcomes for all New Yorkers. Additionally, the SHIN-NY has been leveraged during the COVID-19 pandemic to support disease surveillance activities and assess hospital capacity. Work in this area continues

and the SHIN-NY will likely become an important component in all NYSDOH emergency preparedness initiatives.

### **Reduce Avoidable Hospital Use (CC)**

The primary stated goal of NYS's DSRIP program was to reduce avoidable inpatient and emergency department hospital use by 25% over five years, with broader goals of sustainable system transformation and improvements in population health. As previously stated, this program has a formal evaluation plan and state-contract Independent Evaluator. The final Summative Evaluation is currently being completed, with preliminary results not yet published, but demonstrating significant progress was made towards the achievement of targets. The interim evaluation report is available here:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2019/docs/interim\\_eval\\_rpt.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2019/docs/interim_eval_rpt.pdf)

## **Process for Quality Strategy Evaluation, Revision and Transparency**

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NYSDOH contracts 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 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 annually assess the QS objectives. 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. 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.

Per CMS requirements, the QS was 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. In addition, NYS consulted with Tribes in NYS in accordance with the NYSDOH Tribal Consultation policy. A summary of comments received during the comment period is below.

NYSDOH received one comment from Maxim Healthcare. Maxim Healthcare is a national provider of home healthcare, homecare, and additional in-home service options with seven offices caring for over 1,700 individuals throughout New York, primarily offering private duty nursing (PDN) services as a licensed home care services agency (LHCSA) and Fiscal Intermediary (FI) in the Consumer Directed Personal Assistance Program (CDPAP). While Maxim expressed their support for the goals and metrics outlined in the QS, they also offered specific recommendations for additional quality measures to assess quality indicators for licensed home care services agencies (LHCSAs) and fiscal intermediaries (FIs) such as patient experience, percentage of hours filled, and number of individuals that are authorized for services that are not receiving them. Maxim Healthcare also offered three proposals for managing costs while bolstering quality of care. These proposals include (1) monitoring the percentage of shifts that are unfilled by Managed Medicaid members who are eligible to receive Private Duty Nursing (PDN), (2) adopting a quality metric around network adequacy, and (3) conducting a rate analysis comparing uncovered shifts and provider rates. Lastly, Maxim Healthcare suggested that NYS adopt the quadruple aim in the QS to include goals and metrics around provider satisfaction and the clinical experience. NYSDOH thanks Maxim Healthcare for their comments and will consider these recommendations when drafting the next version of the QS. No changes were made to the QS as a result of this comment.

The current QS can be found on the NYSDOH's public website at: [Quality Strategy for the New York State Medicaid Managed Care Program \(ny.gov\)](#)

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 24 quality measures included in the QS.

# Appendix 1

Metric Name	Metric Source	Population	Baseline Year	Baseline Result	Target	Methodology for Target
Postpartum Care (PPC)	QARR	MMC, CHPlus, HARP, HIV-SNP,	2019	83	84	QISMC
Maternal Mortality Rate in NYS	NYS Vital Statistics	All NYS	2015-2017	18.9/100,000	16/100,000	QISMC
Lead Screening in Children	QARR	MMC, CHPlus	2019	89	90	QISMC
Percentage of Total Members Receiving Oral Health Services by a Non-Dental Provider	Form CMS-416: Annual EPSDT Report	MMC only	2019	0.8	1.6	Linear Projection
Comprehensive Diabetes Care: HbA1c Testing (ages 18 - 64 years)	QARR	MMC, CHPlus, HARP, HIV-SNP	2019	93	94	QISMC
Asthma Medication Ratio (5-18)	QARR	MMC and CHPlus	2019	66	67	QISMC
Asthma Medication Ratio (19-64)	QARR	MMC, HARP, HIV-SNP	2019	55	56	QISMC
Controlling High Blood Pressure (ages 18 - 64 years)	QARR	MMC, CHPlus, HARP, HIV-SNP	2019	67	68	QISMC
Follow-up After Emergency Department Visit for Mental Illness (ages 18 - 64 years) within 30 days (FUM)	QARR	MMC, HARP, HIV-SNP	2019	72	73	QISMC
Depression Screening and Testing	QARR	MMC, HARP, HIV-SNP	N/A	TBD	TBD	N/A
Depression Screening and Follow-up for Adolescents and Adults (DSF-E)	QARR	MMC, CHPlus, HARP, HIV-SNP	N/A	TBD	TBD	N/A
Percentage of high school students reporting current use of alcohol, binge drinking, marijuana, on at least one day during the past 30 days	YRBSS	Subset of High School students in NYS	2019	Alcohol: 26.4% Binge: 12.7% Marijuana: 19.1%	Alcohol: 23.6% Binge: 10.8% Marijuana: 17.1%	Lower confidence interval of the most recent year of data
Percentage of adult use of binge alcohol, marijuana, cocaine, heroin, other drugs	NSDUH	All NYS - NSDUH is representative of persons aged 12 and over in the civilian noninstitutionalized population of the United States, and in each state and the District of Columbia (D.C.). Measure values are just >18yo.	2017-2018	Alcohol Binge: 25.48% Marijuana: 10.05% Cocaine: 2.82% Heroin: 0.3% Illicit Drug Use Other Than Marijuana: 3.42%	Alcohol Binge: 24% Marijuana: 9.14% Cocaine: 2.37% Heroin: 0.17% Illicit Drug Use Other Than Marijuana: 2.94%	Lower confidence interval of the most recent year of data
Medicaid smoking prevalence (Calculated from BRFSS Survey Data)	BRFSS	MMC and FFS	2019	23	21.4	Linear Projection
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence (POD-N)	QARR	MMC, HARP, HIV-SNP	2019	37	38	QISMC
Initiation of alcohol and other drug dependence treatment (18+ Years)	QARR	MMC, HARP, HIV-SNP	2019	50	51	QISMC
Engagement of alcohol and other drug dependence treatment (18+ Years)	QARR	MMC, HARP, HIV-SNP	2019	20	21	QISMC
MMC population impacted by Patient-Centered Medical Home (PCMH) sites of recognition 2014 level 3 and up- active	NYS PCMH Quarterly Reports	MMC	2019	69	70	With the expectation of 4% increase on newly recognized providers, the target is set to 70% to reflect the 3% drop due to practices with recognition set to expire.



Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection.	UAS-NY/SPARCS	MLTC	2019	2.76	2.7	QISMC
Percentage of members who rated the helpfulness of the plan in assisting them and their family to manage their illnesses about their plan of care	MLTC Survey	MLTC	2019	86	87	QISMC
Appropriate Treatment for Upper Respiratory Infections (URI) - Children (3 months to 17 years)	QARR	MMC and CHPlus	2019	94	95	QISMC
Appropriate Treatment for Upper Respiratory Infections (URI)- Adults (18-64 years)	QARR	MMC, HARP, HIV-SNP	2019	72	73	QISMC
Potentially Preventable Admissions (per 100,000)	3M PPA	MMC	2019	1153	1124-1181	The target range has been calculated using a +/- 2.5% of the 2019 rate.
Potentially Preventable Admission Expenditures / Total Inpatient Expenditures	3M PPA	MMC	2019	9.97	7.47-12.47	The target range has been calculated using a +/- 2.5% of the 2019 rate.
Potentially Preventable Admissions (per 100,000)	3M PPA	MMC and FFS	2019	1097	1069-1124	The target range has been calculated using a +/- 2.5% of the 2019 rate.
Potentially Preventable Admission Expenditures / Total Inpatient Expenditures	3M PPA	MMC and FFS	2019	10.33	7.83-12.83	The target range has been calculated using a +/- 2.5% of the 2019 rate.

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