
New York State Department of Health
Integrated Care Workgroup
Final Report

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Executive Summary

New York’s State Health Innovation Plan (SHIP) is the roadmap to achieve the “Triple Aim” for all New Yorkers: healthier people, better care, and lower health care costs. New York will achieve these goals through a multi-faceted approach that has, as a central component, transformation of the primary care delivery system. This approach requires the participation of multiple payers (public and private) to support ‘advanced’ primary care services characterized by improved access to care, reliable delivery of preventive care, chronic disease management for complex patients, and behavioral health integration. To achieve the aspirations of the SHIP, New York State, in coordination with Health Research Inc., was awarded a four year, \$100 million State Innovations Model (SIM) Testing grant from the Centers for Medicare and Medicaid Innovation (CMMI) beginning in February 2015. The SHIP is a statewide, multiagency effort and the SIM Testing grant is coordinated directly by the New York State Department of Health (NYSDOH) in close collaboration with the New York State Department of Financial Services (DFS).

Overarching goals of the SHIP, consistent with the Triple Aim, are to support a care delivery model that results in the following by 2020:

- 80 percent of the population is cared for in primary care practices receiving non-visit, non-volume based reimbursement – that is, an alternative (or ‘value-based’) payment model
- 80 percent of the population receives care within a primary care practice that has the capabilities described in our APC milestones

To achieve these goals and advance the Triple Aim in New York, a governance model was developed to include an overarching SHIP Health Innovation Council as well as three (3) specific workgroups: the *Integrated Care Workgroup*, the *Workforce Workgroup*, and the *Transparency, Evaluation, and Health Information Technology Workgroup*.

This report summarizes the work of the Integrated Care Workgroup (ICWG), charged with designing a statewide model for primary care referred to as Advanced Primary Care (APC). This workgroup, comprised of payers, clinicians, consumers, and subject matter experts, assumed the challenge of addressing an array of policy and programmatic issues related to the development of the APC model.

Workgroup Lessons Learned and Insights

The ICWG had a chance to reflect upon the lessons learned through the workgroup deliberation process in designing an effective APC model, practice transformation model, and payment. Some of the major themes of importance that were identified include:

- The value of an open, multi-stakeholder process
- A focus on primary care
- Defining and evolving APC over time
- The diversity of primary care providers and populations
- The need for alignment and innovation
- The role of payers and purchasers
- The role of patients and families

These themes are described in more detail in the report.

Workgroup Achievements

Since its inception, the ICWG has achieved the following:

- *Established APC Care Model Capabilities:* Building on existing multi-payer advanced primary care/medical home initiatives in New York and throughout the country, along with a growing evidence base, the ICWG provided the input to the development of the design of the APC model. Design elements include detailed specifications, standards and milestones for assessing a primary care practice's achievements; a common set of measures to be used to evaluate the practice's impact on improving quality and population health; and methodologies to reduce avoidable utilization and costs.
- *Established Practice Transformation Model:* Through its deliberations, the ICWG developed parameters for practice transformation to support APC. The NYSDOH developed and issued a Request for Applications (RFA) to vendors of practice transformation technical assistance to help practices achieve APC capabilities. Applications for that funding have been received, and are presently under review by the NYSDOH to move forward with contracts.
- *Value-Based Payment for APC:* Substantial progress has been made in generating support by the state's commercial payers. The scope includes multi-payer supported primary care reform coupled with value-based payments. Together, both are critical to achieving and sustaining advanced services necessary for achieving the triple aim, and which are not otherwise adequately supported by traditional fee-for-service models.

With these accomplishments, New York is moving from a collaborative, multi-stakeholder planning and design phase to implementing and operationalizing the APC model. Accordingly, the oversight and management of this effort is evolving, from one focused on establishing statewide policy and overall recommendations to a hybrid model also including regional approaches. The ICWG will be succeeded by a smaller statewide APC steering committee focused on the major remaining challenges of implementation; and regional oversight and management councils to oversee and guide the implementation of APC in diverse communities across the state. These regional councils will track and assist in the implementation of the practice transformation efforts in primary care practices within their regions, and work with regional (and statewide) payers to advance the implementation and coordination of multi-payer initiatives focused on advanced primary care.

Background

New York's State Health Innovation Plan (SHIP) is the roadmap to achieve the "Triple Aim" for all New Yorkers: healthier people, better care and lower health care costs. New York is pursuing a multi-faceted approach that has, at its heart, an advanced primary care model facilitating more integrated and coordinated care for patients coupled with equally 'advanced' payment approaches that supports and rewards high value care.

To help achieve these ambitious goals New York State, in coordination with Health Research, Inc., applied for and was awarded a four year, \$100 million State Innovations Model (SIM) Testing grant from the Centers for Medicare and Medicaid Innovation (CMMI) with a start date of February 2015.

The overarching goals of New York's SIM are to support the development and dissemination of a care delivery model that by 2020 will result in a statewide delivery system in which 80 percent of the population receives primary care within an APC setting. The objective is to provide:

- A systematic approach to primary care based prevention services, care coordination and care management for high risk patients, use of quality metrics for improvement, integration of behavioral health services and population health management
- A payment environment in which primary care is supported by alternative payment models across a critical mass of payers that recognize primary care providers for advanced services (including non-visit or procedure based interventions) and rewards them for improved performance.¹

The core of New York's primary care initiative is the development and implementation of the APC model within practices, facilitated by regional practice transformation organizations, supported by SIM grant funds, to work with interested and engaged practices. A competitive procurement was issued in March 2016, with initial implementation across New York anticipated to begin fall 2016.

As part of the planning process, the NYSDOH launched a multi-agency, multi-sector governance structure. This included creation of several workgroups including an Integrated Care Workgroup (ICWG) charged to engage payers, clinicians, and consumers in the development of the Advanced Primary Care (APC) model and its supporting components (value-based payment, common metrics, and alignment with behavioral and population health).

The ICWG's charge had four main elements:

- Create a vision for Advanced Primary Care (APC) that promotes the coordination of care for patients across specialties and care settings, improves patient experience and clinical quality, and reduces avoidable costs.
- Align measurement across payers to accelerate improvement efforts, promote consistency and

¹ Additional information on the NY SIM award and implementation of the SHIP may be found here: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_hip_implementation.pdf

parsimony, and support provider and payer focus on a key set of meaningful measures.

- Provide guidance on how to best develop statewide primary care practice improvements, and alternative payment strategies.
- Catalyze multi-payer (including commercial, Medicaid, and Medicare) investments in primary care practices; initial investments in achieving a higher-performing primary care system, and payment change to recognize and support the increased operating costs of this high-value model; and to ensure aligned incentives and supports necessary to achieve the Triple Aim.

The ICWG's first year (CY 2015) was devoted to planning and design, in preparing for implementation in mid-late 2016, which is now under way. This report outlines the accomplishments and findings of the workgroup as the state pivots to implementation and a new governing structure for the rollout of APC. This report is intended to capture the discussions that led to the design decisions for APC, and was prepared by the Department of Health to document the deliberations of the ICWG. Workgroup members were invited to provide corrections or comments to the draft of this report. This report will be made publically available to reach a broad audience interested in the development of the APC model in New York.

Accomplishments

Over the past 18 months, the ICWG has emerged as the State's focal point for development of a multi-payer model for advanced primary care. The ICWG, a dedicated and diverse group, included clinicians, health care providers, payers, consumers and professional organizations. The group has served as an important forum for multi-stakeholder engagement, discussion, and consensus building and has made progress in reaching its objectives.

Assumptions: The ICWG established an initial set of Assumptions², which guided deliberations:

- Improved access to high quality primary care is key to improving value in health care and achieving triple aim goals.
- Practices and payers need a compelling clinical and payment model to invest in transformation.
- A practice meeting any 'standard' (NCQA's Patient-Centered Medical Home (PCMH) or others) is helpful but not a sufficient guarantee for meaningful, sustainable practice improvement.
- Transformational changes in practice will remain limited if care is reimbursed on a FFS basis rewarding volume over value/quality.
- Maximizing transformation investments is conditional on reaching agreement regarding a common set of milestones for Advanced Primary Care aligned with SHIP goals.

Defining the Model: Over the past year, supported by key NYSDOH, DFS, and Office of Mental Health (OMH) staff, the ICWG finalized the design of the APC model, taking APC from an abstract concept to a concrete plan for implementation.

The ICWG deliberated on many model components, including but not limited to incorporation of population health, which was ultimately integrated into the model and is reflected in both milestones and measures.

Through these discussions and model evolutions, the ICWG defined the following major elements of APC:

1. Capabilities that describe an Advanced Primary Care practice (Figure 1), including patient-centered care, population health, integrated behavioral healthcare, care management, access to care, HIT, alternate payment model, and quality and performance
2. Core quality measures that reflect a practice's impact on patient health, quality of care, and experience (Figure 4) across six domains: prevention, chronic disease, behavioral health/substance use, patient-reported outcomes, appropriate use, and cost
3. Gates that define practice transformation achievements over time and inform payers regarding timing and purpose of prospective reimbursement (Figure 2)
4. Milestones that define specific expectations of a practice in terms of key capabilities and performance against core measures (Figure 3)
5. Initial design of a quality measure scorecard that will enable stakeholders (clinicians,

² ICWG presentation, Meeting 1, January 15, 2015:

http://www.health.ny.gov/technology/innovation_plan_initiative/docs/2015-01-16_integrated_care_presentation.pdf

payers, consumers, and the state) to track and evaluate the progress of the SIM and APC, in improving the quality and cost-effectiveness of care in practices that are implementing advanced primary care models.

The major design elements for APC considered by the workgroup, are highlighted in Figures 1-4 below. These figures represent the components agreed upon by the workgroup as the State moves forward with implementation of APC. While these figures are high-level depictions of the APC model components, there is greater detail in supporting technical documentation developed by the NYSDOH. These figures are the result of Workgroup discussion and deliberation, and included several rounds of comment and refinement directly in the Workgroup and through additional stakeholder discussions. A brief overview of each figure is described below.

Figure 1: APC Practice Capabilities

Figure 1 includes the seven major domains for practice capabilities envisioned under APC. These are the high level domains, which link directly to the Structural Milestones. These are the major elements of care delivery included in APC that have sufficient evidence linking them to enhanced patient experience and improved clinical care, while also helping clinicians and practices transition to increased value-based payments.

Figure 2: APC Gates

This figure demonstrates the journey for practices in their evolution through APC, as they advance through three “gates” defining graduated levels of practice infrastructure and capacity.

Gate 1: Commitment and preparation

Practices must show evidence of commitment to change as demonstrated by the allocation of appropriate resources and personnel. A shared responsibility between payers and providers in the region is needed to ensure that there is sufficient commitment to the work involved in participating in APC.

Gate 2: Readiness for care coordination including payment

Reaching Gate 2 indicates a practice’s readiness to provide effective care coordination. Necessary capabilities at this point include:

- The ability to identify high-risk patients and successfully measure and report the Core Measures derived from practice data.
- Capacity to provide care coordination for high-risk patients within one year.
- Infrastructure and commitment to use results from APC Core measures for improvement.

Gate 3: Demonstration of APC capabilities and performance

One year after meeting Gate 2 (or sooner if ready), practices will have to demonstrate active care management and coordination for a majority of their high-risk patients. At this point, they will be required to connect to their regional health information exchange (RHIO). Importantly,

demonstrating APC capabilities implies moving from an ability to measure performance to the ability to demonstrate improvements in quality and reduced preventable costs.

The milestones within each gate are detailed in the Structural Milestones.

Figure 3: APC Structural Milestones

For each of the seven APC milestone categories at each gate of APC, the Workgroup developed structural milestones to clearly define the capabilities of APC. These milestones further define the expectations for each category of APC.

Figure 4: Core Measures

To ensure alignment and minimize the number of unique measures required to be reported by each plan and practice, a common set of core measures has been developed for use by APC participating payers and practices. APC core measures will be reported as part of an APC provider scorecard and used for evaluation and performance based payments. This figure is the core quality measure set discussed in the Workgroup that reflect a practice's impact on patient health, quality of care, and experience.

Figure 1. APC Practice Capabilities

Category	Description
Patient-centered care	<ul style="list-style-type: none"> Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	<ul style="list-style-type: none"> Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/coordination	<ul style="list-style-type: none"> Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	<ul style="list-style-type: none"> Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	<ul style="list-style-type: none"> Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	<ul style="list-style-type: none"> Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	<ul style="list-style-type: none"> Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Figure 2. APC Gates

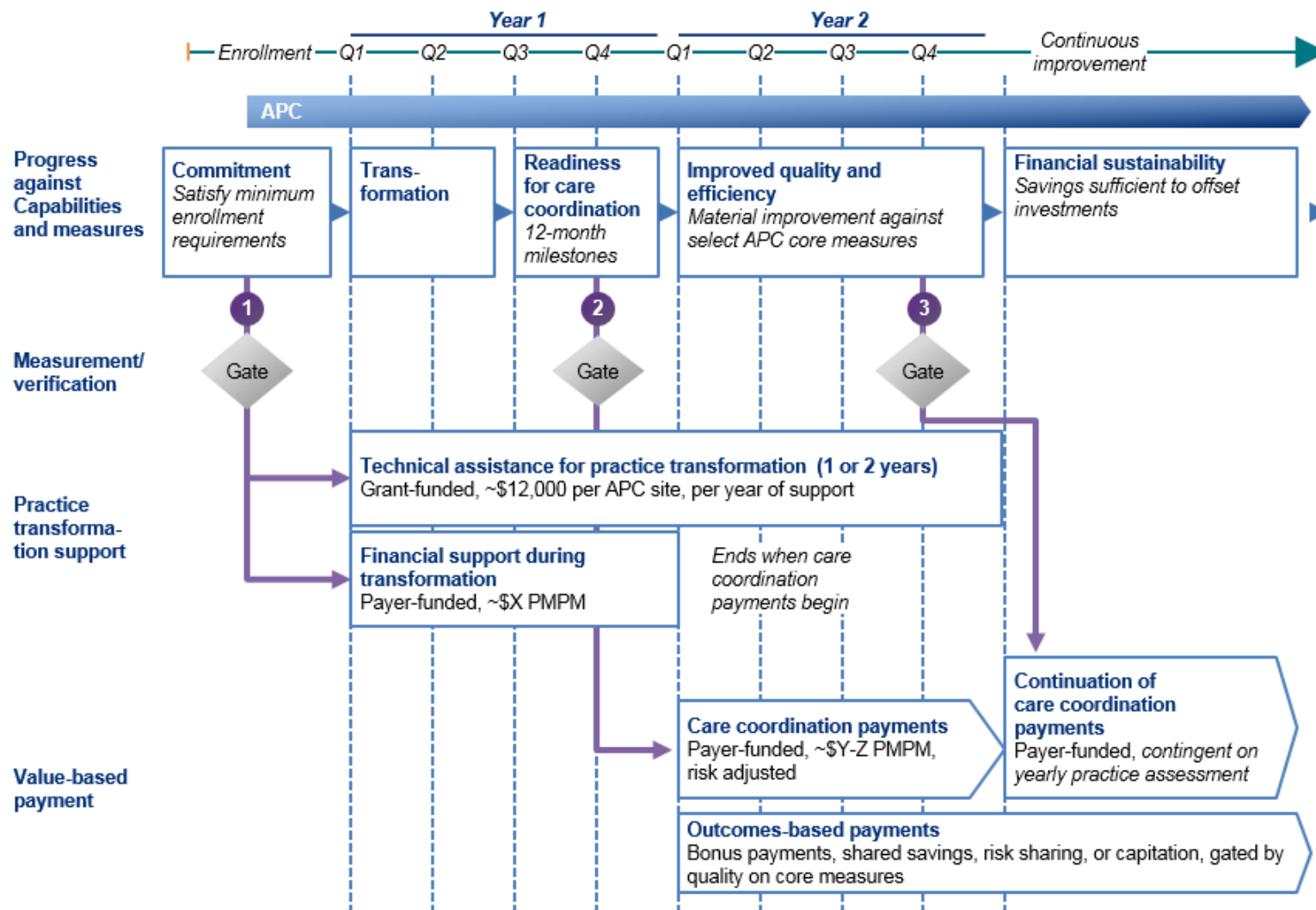





Figure 3. APC Structural Milestones

	Commitment  Gate 1	Readiness for care coordination  Gate 2	Demonstrated APC Capabilities  Gate 3
	<i>What a practice achieves on its own, before any TA or multi-payer financial support</i>	<i>What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet</i> Prior milestones, plus ...	<i>What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination</i> Prior milestones, plus ...
Participation	<ul style="list-style-type: none"> i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year 	<ul style="list-style-type: none"> i. Participation in TA Entity activities and learning (if electing support) 	
Patient-centered care	<ul style="list-style-type: none"> i. Process for Advanced Directive discussions with all patients 	<ul style="list-style-type: none"> i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year 	<ul style="list-style-type: none"> i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
Population health			<ul style="list-style-type: none"> i. Participate in local Prevention Agenda activities ii. Annual identification and outreach to patients due for preventive or chronic care management iii. Process to refer to self-management and community-based resources
Care Management/Coord.	<ul style="list-style-type: none"> i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year 	<ul style="list-style-type: none"> i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate¹, and referral 	<ul style="list-style-type: none"> i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Access to care	<ul style="list-style-type: none"> i. 24/7 access to a provider 	<ul style="list-style-type: none"> i. Same-day appointments ii. Culturally and linguistically appropriate services 	<ul style="list-style-type: none"> i. At least 1 session weekly during non-traditional hours
HIT	<ul style="list-style-type: none"> i. Plan for achieving Gate 2 milestones within one year 	<ul style="list-style-type: none"> i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year 	<ul style="list-style-type: none"> i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Payment model	<ul style="list-style-type: none"> i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year 	<ul style="list-style-type: none"> i. Minimum FFS with P4P² contracts with APC-participating payers representing 60% of panel 	<ul style="list-style-type: none"> i. Minimum FFS + gainsharing³ contracts with APC-participating payers representing 60% of panel

1 Uncomplicated, non-psychotic depression

2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework

3 Equivalent to Category 3 in the APM framework

Figure 4. APC Core Measures

Domains	NQF #/Developer	Version 1/Data Source	Measures	Version 1
Prevention	32/HEDIS	Claims/EHR. Claims-only possible.	Cervical Cancer Screening	✓
	2372/HEDIS	Claims/EHR. Claims-only possible.	Breast Cancer Screening	✓
	34/HEDIS	Claims/EHR	Colorectal Cancer Screening	
	33/HEDIS	Claims/EHR. Claims-only possible	Chlamydia Screening	✓
	41/AMA	Claims/EHR/Survey.	Influenza Immunization - all ages	
	38/HEDIS	Claims/EHR/Survey. Claims-only possible.	Childhood Immunization (status)	✓
	2528/ADA	Claims	Fluoride Varnish Application	✓
Chronic Disease	28/AMA	Claims/EHR	Tobacco Use Screening and Intervention	
	18/HEDIS	Claims/EHR	Controlling High Blood Pressure	
	59/HEDIS	Claims/EHR	Comprehensive Diabetes Care: HbA1C Poor Control	
	57/HEDIS	Claims	Comprehensive Diabetes Care: HbA1C Testing	✓
	55/HEDIS	Claims	Comprehensive Diabetes Care: Eye Exam	✓
	56/HEDIS	Claims	Comprehensive Diabetes Care: Foot Exam	
	62/HEDIS	Claims	Comprehensive Diabetes Care: Medical Attention for Nephropathy	✓
	71/HEDIS	Claims/EHR	Persistent Beta Blocker Treatment after Heart Attack	✓
	1799/HEDIS	Claims/EHR. Claims-only possible.	Medication Management for People With Asthma	✓
	24/HEDIS	Claims/EHR	[Combined obesity measure] Weight Assessment and Counseling for nutrition and physical activity for children and adolescents	
Behavioral Health/ Substance Use	421/CMS	Claims/EHR	[Combined obesity measure] Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	
	418/CMS	Claims/EHR	Screening for Clinical Depression and Follow-up Plan	
Patient-Reported	4/HEDIS	Claims	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓
	105/HEDIS	Claims/EHR. Claims-only possible.	Antidepressant Medication Management	✓
Appropriate Use	326/HEDIS	Claims/EHR	Advance Care Plan	
	5/AHRQ	Survey	CAHPS Access to Care, Getting Care Quickly	
	52/HEDIS	Claims	Use of Imaging Studies for Low Back Pain	✓
	58/HEDIS	Claims	Avoidance of Antibiotic Treatment in adults with acute bronchitis	✓
	--/HEDIS	Claims	Inpatient Hospital Utilization (HEDIS)	✓
Cost	1768/HEDIS	Claims	All-Cause Readmissions	✓
	--/HEDIS	Claims	Emergency Department Utilization	✓
	--	Claims	Total Cost Per Member Per Month	✓

Practice Transformation Technical Assistance: A majority of the state’s SIM grant award is dedicated to supporting a regionally-based program of practice transformation technical assistance. This technical assistance will be provided by entities charged with helping practices through guidance on goal-setting, leadership, practice facilitation, workflow changes, outcome measurements, and adapting organizational tools and processes to support a team-based model of care delivery. Practice transformation support will be predicated on an initial evaluation of practice readiness, evidence of support from relevant payers for value-based payment, and tailored to their needs.

Under the oversight of the ICWG, the NYSDOH released an RFA³ requesting proposals from vendors of primary care practice transformation technical assistance across different regions of the state. Funded contractors will be expected to assist practices and providers to develop the systems and processes necessary to meet the goals of the Triple Aim (described previously in this report). Contracts are anticipated to be executed in November.

Payment Change to Support Advanced Primary Care: Several commercial payers as well as the New York Health Plan Association have been involved in the ICWG since its inception, providing valuable input into the process. NYSDOH and DFS completed an initial effort to request, receive, and analyze information from health plans in the State of New York regarding initiatives to support primary care transformation and expand payment innovations⁴. Major findings included: Every plan identified at least one alternative or outcome based program, and a majority of plans currently provide some level of practice transformation support (either financial or technical support) to certain practices deemed ready for the introduction of advanced primary care services.

Throughout 2015 and 2016, with the support of the Northeast Business Group on Health (NEBGH), the NYSDOH and DFS held a series of payer and purchaser forums, to explore options and opportunities for expanding payment innovations in support of the APC model. Over the past few months, NEBGH, NYSDOH, and NYSDFS conducted a series of one-on-one discussions with individual plans to better understand their current programs and plans for expanding value-based payment methods for various models of advanced primary care.

Purchasers have been actively engaged in discussions of APC, and play a critical role in shifting reimbursement from fee-for-service to paying for value. Since 2015, NEBGH has been successful in engaging numerous payers and purchasers (21 health plans and 69 purchasers) and building support for a multi-payer approach throughout New York State by conducting:

- Introductory webinars in June and September 2015
- 1 benefit consultant meeting on September 17, 2015
- Webinar with General Electric on December 15, 2015
- 20 regional meetings across New York State from July 2015 through July 2016
- 7 multi-payer meetings from August 2015 through May 2016
- 3 Purchaser Advisory Council (PAC) meetings from November 2015 through April 2016
- 1 SIM Educational Program: NEBGH Half Day Conference *The ABCs of ACOs, APC and PCMH* on February 23, 2016
- Webinar with Anthem health plan account executives on March 1, 2016

³ Practice Transformation RFA: <https://www.healthresearch.org/rfarfp-rfa-qps-2016-02/>

⁴ The payer Request for Information is available at the following link, with supporting material on the ICWG page: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/apc_payer_information_request.pdf

- 1 Joint health plan / purchaser meeting on June 30, 2016

These sessions have provided the NYSDOH and DFS with a much greater understanding and insight into how plans are approaching medical home designation among primary care practices in their networks, and how they are paying – and planning to pay – for those services, and they have informed the deliberations of the ICWG. These sessions are also providing a far more detailed perspective on the baseline status of investment in primary care, which is critical to reaching the state’s goal of achieving broad-based, consistent, multi-payer support for the APC model. The one-on-one plan meetings are providing concrete next steps for multi-payer launch of the APC model in each region of the State.

Lessons Learned and Insights

At its July 2016 meeting, the ICWG members had an opportunity to consider the achievements to date, as well as some of the challenges that remain. Below are some of the consistent themes that emerged from that discussion.

The Value of an Open, Multi-Stakeholder Process

ICWG members observed the critical value of having a broad-based, multi-stakeholder group such as the ICWG. The membership, organization and facilitation of discussions, including productive disagreements, were essential to achieving legitimacy and a broad base of consensus. The facilitation of the workgroup's meetings was essential for the creation of an open and inclusive environment in which to resolve complex health care delivery choices. This was perceived as a critical component of success as was the statesmanship and flexibility of all the participants.

There was a consensus among the members of the ICWG that having a statewide process focused on statewide policy and program oversight would continue to be essential in the next implementation phase of APC initiative.

There was a recognition of the need for regional collaboration, to build and maintain local relationships between and among primary care clinicians, payers, and other key community leaders in health care and to support the creation of effective medical neighborhoods supporting health care delivery and payment reforms. New York State is large and complex, and it will be difficult to achieve alignment through a voluntary program without regional engagement. Responsibility for regional oversight functions includes reaching agreement among major payers and providers, with input by major purchasers and other stakeholders, with a level of oversight and reporting to NYSDOH through the statewide committee. Key functions will include facilitation by a content expert, convening meetings and calls, and making productive use of on-going qualitative and quantitative information to guide progress over time. While details are still being resolved as to how this will occur, the approach strives to provide optimal balance between statewide coordination and regional variation.

Focused on Primary Care

The ICWG members observed the importance of having a group focused specifically on improving primary care across New York State as fundamental to health care reform efforts, focused on the goals and objectives as described in the SHIP and SIM. The specific focus enabled the ICWG to work concretely and effectively to define APC, to elaborate those components necessary to support practice transformation, and to engage meaningfully with payers about the need to develop and adapt payment methods to support and sustain that model of primary care.

Defining and Evolving APC over Time

As a result of the deliberations of the ICWG, there is a robust model for Advanced Primary Care and a concrete plan for statewide implementation. The ICWG has honed performance and outcome measures in ways that are meaningful and measureable. APC has evolved from thoughts and concepts to tangible Milestones and Gates for advancing capabilities in primary care. The delineation of a limited, focused set of initial Core Measures was recognized as a signal achievement. There was support for efforts aimed to

create both parsimony and relevance regarding performance measures directed to primary care practices. Development of a standard APC Scorecard for providers and payers to use to assess primary care practices' performance was noted as an essential part of the process.

The ICWG recommended the inclusion of behavioral health as an integral part of the APC model along with specific behavioral health Standards and Milestones. Similarly, the inclusion of discrete Standards and Milestones for improving population health and community linkages was considered to be an important and differentiating characteristic of APC standards.

The ICWG members recognized the need to move progressively with APC as an iterative process, with the expectation that the model would need to evolve over time as clinicians/providers, payers, and policy makers in NYS gain experience from APC implementation and respond to new evidence and new thinking regarding advanced primary care services and payment reform.

The Diversity of Primary Care Providers and Populations

One of the key and recurring themes during the ICWG's considerations was the diversity of New York's primary care base, which is composed of practices of very different sizes, organizational structures and relationships (ranging from large group practices, hospital-affiliated clinics, practices, and FQHCs, to small, independent practices) with widely-differing capacities and infrastructure. It is important for the roll-out of the APC program to be nuanced to respond to that diversity, to meet practices where they are.

It was regularly noted that the APC model requires certain capabilities to enable effectiveness. Practices should have an existing infrastructure that supports team based care and data use and exchange. These capabilities enable practices to be in better position initially to adopt APC, as with any quality/value-based model. Smaller practices (such as those with 5 or fewer providers, which represent a sizeable portion of the state's primary care workforce) may have specific challenges meeting some of APC's capabilities, and may merit separate consideration. On the other hand, it was pointed out that larger, complex health care institutions may be less nimble than smaller practices with respect to the implementation of changes in workflow or investment in new staff or services.

The Need for Alignment and Innovation

Given an existing complex landscape of multiple care models and several state and federal initiatives that offer different opportunities for primary care practices (both care and/or payment reform), it was clear from the start to the ICWG that continuing attention to simplify, coordinate and improve communication and awareness of APC as it relates to these other initiatives, was central to its success. Specifically, ICWG members noted the need to better align the APC model with other, potentially competing, models of practice transformation at regional, statewide, and national levels (NCQA's PCMH, DSRIP, ACO, CPC+, and the TCPI program), all of which are now under way in NYS, in order to reduce confusion among the primary care community. The State is working actively to coordinate with CMS on aligning programs and avoiding duplication of efforts, while also working internally within NYSDOH to align programs and communications on available practice transformation opportunities for practices. An example of one communications tool to help differentiate between programs is included in Figure 5.

Figure 5. Technical Assistance and Transformation Programs

NEW YORK STATE
Department of Health
Innovation Center

Technical Assistance for Primary Care Practices: What Are My Options?

START

	OVERVIEW	BEST OPTIONS	DURATION	VALUE PROPOSITION
APC	<p>Program Description Federal and state programs are offering resources and technical assistance to help practices prepare for changing expectations for primary care coupled with an evolving "value-based" reimbursement environment. These four programs have different features and eligibility requirements but are aligned in: providing assistance to practices interested in improving care delivery to their patients, becoming comfortable with the use of data to evaluate practice performance, and providing team-based care that includes care coordination/management for complex, high-need patients.</p> <ul style="list-style-type: none"> Technical Assistance (TA) is provided to reach APC milestones with up to two years of support through 2019 Directed at practices with existing or planned value-based contracts sufficient to support practice changes leading to non-visit-based care and services 	<p>For Your Practice Depending on your professional goals, characteristics of your practice, business affiliation and payer mix, the programs below may have variable application or interest to you. Most programs do not allow any "duplication" of funding (paying for the same assistance at the same time) and may have eligibility or exclusion rules as applicable.</p> <ul style="list-style-type: none"> Practices are eligible for TA beginning at Gate 1 if committed to implementing APC services ("Gates" are determined by level of competency) Priority is for small-medium-size practices with multiple private/public payer participation Successful completion of TCPI and/or NQQA PCMH 2014 Level 3 counts as "credit" towards APC milestones 	<p>How long will it take? This greatly depends on current capacity and professional goals. Experience with "medical home" and "advanced primary care" has demonstrated that many practice changes take from one to three years to fully implement. Technical assistance support duration will vary depending on practice assessments, need, goals, and the specific program chosen.</p> <ul style="list-style-type: none"> Modular Milestone curriculum design with direct TA: practices progress through gates at own pace over time Milestone completion is assessed by technical assistance and validation vendors as practices advance Technical assistance vendors provide combination of on-site, remote, and collaborative learning and coaching 	<p>Financial Landscape Increasingly value-based payments depend on practices being able to demonstrate high quality, improved patient access and experience of care, as well as reduction of avoidable costs. These technical assistance programs were developed to coach practices in developing the needed infrastructure and workflows that increase the likelihood of success with value-based payments. Some programs and payers are also providing prospective payments to help support practice transitions.</p> <ul style="list-style-type: none"> APC is a multi-payer initiative that provides practice support tools to maximize payer value-based payment arrangements Participating payers, along with key stakeholders, are actively engaged in design and operation of the APC Model Payers are asked to provide some form of prospective support to practices to assist with development of practice capacity and infrastructure, in addition to offering value-based payments based on performance
CPC+	<ul style="list-style-type: none"> Five-year CMMI-directed primary care program engaging seven of the previous national CPCi regional practices/payers with potential for up to 3,000 additional practices nationally Two Tracks. Requires use of 2014 CEHRT and, at Track 2, an MOU with CMS and HIT vendor https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus 	<ul style="list-style-type: none"> North Hudson-Capital Region, with specific applicable counties have been selected to participate in CPC+. For more information on eligibility and enrollment: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus Eligible primary care: any existing CPCi or primary care practice not participating in other CMS-funded programs such as FQHC's, certain MSSP ACOs and current/former MAP-CP, SIM states with Medicaid participation Recognition under the NYS APC model 	<ul style="list-style-type: none"> Eligible for overarching support from CMMI and regional learning faculty and utilization data to practices Tracks 1 and 2 require quarterly measures (eCQM) and milestone threshold reporting with more rigor for Track 2 CPC+ practices are self-navigated, self-reporting and are provided with distance learning opportunities 	<ul style="list-style-type: none"> Ongoing Medicare, commercial performance-based incentive payments during transformation cycles for both tracks averaging \$15 PBPM under Track 1 and \$28 PBPM under Track 2. Commercial payers provide performance-based payments for both tracks
DSRIP	<ul style="list-style-type: none"> Five-year program through 2020 Participants must be Medicaid providers and belong to a Performing Provider System (PPS) For primary care practices in DSRIP, the goal is to achieve NQQA PCMH 2014 Level 3 or APC http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/ 	<ul style="list-style-type: none"> Practices work with their PPS to achieve NQQA PCMH 2014 Level 3 or APC Practices may receive support from APC or TCPI as long as the support they receive from these programs is not the same support they receive from the PPS 	<ul style="list-style-type: none"> Primary care practices participating within DSRIP are expected to be recognized as NQQA PCMH 2014 Level 3 or APC by March 31, 2018 Primary care practices already recognized as PCMH 2014 Level 3 are eligible for advanced gating in APC through 2019 	<ul style="list-style-type: none"> By the end of DSRIP (March 2020), 80-90% of managed care payments to providers are expected to be in value-based payment arrangements
TCPI	<ul style="list-style-type: none"> PQRS-eligible, critical access hospitals, FQHCs, network providers, and FFS practices Four-year program through mid-2019. Ongoing recruitment/eligibility for TA Requires use of 2014 CEHRT http://www.nyhealth.org/nysplr/ 	<ul style="list-style-type: none"> Practices are eligible for no-cost TA upon completion of the standard curriculum. Practices are also eligible for participation in APC/Value-Based Payments (VBP) Practices are ineligible if they are a Pioneer ACO, MAP-CP, CPC+ or other CMMI-supported program 	<ul style="list-style-type: none"> Practices are eligible for peer-based learning, coaching with ongoing support from TAs and national Support Alignment Networks (SANs) through a more rapid cycle-change process using LEAN and Six Sigma as hallmarks in transformation Quarterly reporting is required 	<ul style="list-style-type: none"> TCPI practices receive no-cost TA support and are eligible for quality payments through APC (VBP), MIPS or other APMs upon completion

FINISH
VALUE-BASED
PAYMENTS

For more information on APC:
https://www.health.ny.gov/technology/innovation_plan_initiative/workgroup_integrated_care.htm

For more information on CMS guidance on payment reform:
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>

New York State's DSRIIP program requires that Performing Provider Systems (PPSs) achieve advanced primary care/medical home status for their participating primary care practices, including APC and/or PCMH 2014 as the two available options, by April 1, 2018. Given this, and other concerns regarding the need for alignment and clarity of message, it was a high priority to align that model with the APC model, as well as successor versions including the recently announced NCQA PCMH 2017 standards. The ICWG helped map the PCMH 2014 model into the APC's Standards, Milestones and Gates and allow practices to credit their PCMH 2014 achievements in the NYS APC model.

Technical specifications of the APC Milestones have been synthesized, aligned, and cross-walked with TCPI, NCQA PCMH 2014, and CPC 'Classic' and CPC 'Plus' (CPC+), with provisional performance credit given to applicable competencies of APC Gates. The NYSDOH has initiated a multi-initiative coordinating group (the NYS Practice Transformation Council) which is working on continuing issues of alignment among the various programs. One of its major achievements to date is the creation (by the Center for Health Workforce Studies) of a database to track the statewide implementation of all of the various practice transformation efforts in each engaged practice.

The Role of Payers and Purchasers

Delivery system innovations like APC require changes in the payment system to support them. Without changes in payment for practices engaged in transformational efforts, those practices face substantial financial risk, adding costs and providing services that not only are not recognized or adequately reimbursed under the fee-for-service payment system but which in fact, if provided, can come at the expense of the provision of services and procedures for which they are currently paid.

As part of the input from the ICWG and meetings with payers, DFS recently implemented a proposal that allows insurers to include APC payments along with claims in the pricing medical loss ratio (MLR) formula for 2017 premiums. The MLR adjustment is intended to provide an incentive to insurers to make practice transformation and care coordination payments under the APC model or to expand their current outcome-based primary care programs. Currently, the pricing MLR is the ratio of claims to premiums. With the new formula, the pricing MLR will be the ratio of claims, plus practice transformation and care coordination payments, to premiums. Additional tools to encourage adoption of APC and promote investment in primary care transformation will continue to be discussed in 2017.

One-on-one meetings with health plans, coupled with payer responses to the RFI, generated key issues which need to be considered as the state moves to implement the APC program:

- While the state's health plans are generally supportive of the state's APC initiative and the medical home model, many already have some programs in place to recognize and reward primary care practices and/or ACOs using a variety of 'value-based payment' approaches.
- There is substantial heterogeneity among payers in the primary care delivery models they currently favor including which quality measures and value-based payment models they pursue.
- The state should consider ways to incentivize plans to continue to support primary care programs and APC.

A consistent theme that also emerged from both the RFI and subsequent one-on-one meetings, and continues to be a critical theme is how to respond to, and organize around the variability of advanced care practice capacity, insurer influence in the practice/group (related to percent of patient panel), and the way in which those two factors may intersect. One way of conceptualizing and simplifying this is to categorize practices into groups based on both variables: (1) the level of potential plan influence (often described simply as volume or percent of plan membership in the practice); and (2) practice capacity/interest for delivery of advanced primary care services and value-based payment arrangements. RFI responses revealed different payment approaches for network providers depending on geography, volume, and level of organization (i.e., ACO/IPA or not), as well as insurance type (Medicare, PPO or HMO, etc.). In areas and practices where a single or small number of insurers dominate the market, the perceived relevance of multi-payer, aligned care/payment reform may be very different from those where many payers participate and none have clear major dominance.

As the system moves toward value-based payment arrangements using shared savings and shared risk models, many practices will experience increased operating costs during their transition to being able to provide the services within APC. Predictable support for those practices is essential, at least for a period of time while the practice moving toward APC is gaining experience and beginning to generate improvements in quality and cost that can ultimately be supported by value-based payment (VBP) programs that rely on shared savings and shared risk arrangements.

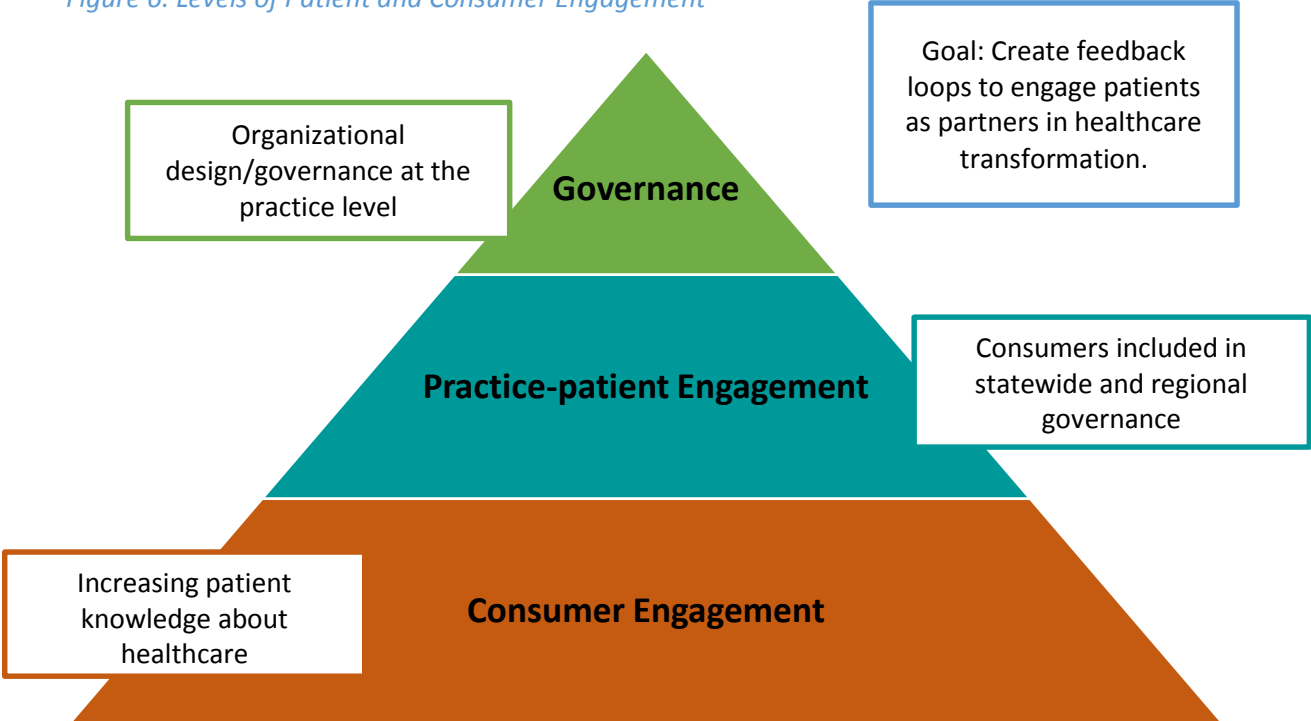
Working with Purchasers

As part of the NEBGH's meetings, there were discussions with large employers, many of them self-insured. Employers, who are the purchasers of health insurance products for their employees and their families, expressed interest and support for the APC model as an investment in the health of their employees and their families, with potential to improve quality and restrain the growth of health care (and benefit) costs. NEBGH will continue to engage employers and develop tools for employers to include APC and other value-based purchasing arrangements in their benefits to help New Yorkers receive high quality care.

The Role of Patients and Families

Multi-stakeholder engagement has been a cornerstone of SIM model development, and will play a role in its successful activation across the different regions of New York State. Consumer engagement has been addressed both through the ICWG and in individual meetings with consumer advocacy groups. Through these substantive discussions, it has been made clear that there are a number of different ways that healthcare consumers can be concretely and systematically engaged in SIM. The state is currently exploring opportunities to further consumer engagement within APC governance models, through competitive procurements, and through existing state efforts.

Figure 6. Levels of Patient and Consumer Engagement



Next Steps

The next six months will be a critical time for the SIM initiative and APC. NYSDOH is currently working to prepare an updated operational plan for APC, including evaluation of the feedback we have received to date from the ICWG. Elements of that plan include:

1. **Practice Transformation:**

This winter, NYSDOH/HRI will be awarding contracts to practice transformation agents, to provide recruitment and engage practices to participate in APC in several regions throughout the state. Due to the complexity and size of New York, this will be a phased-in effort, where regions considered to have immediate potential for APC and adequate payer support for the APC model will lead the launch, in addition to areas critical for DSRIP providers.

2. **Changes in Oversight and Governance:**

As the ICWG completes its work, it will be transformed to a new statewide group, charged to consider and provide input into state policy around the advanced primary care model, to monitor a broad statewide program of practice transformation efforts, and provide guidance to the state's ongoing work with providers and payers about the implementation and operationalization of the APC model. They will also be charged to facilitate the engagement of clinicians, payers, and patients in APC, and provide input into the iteration of the APC model as required.

In addition, as the state prepares to begin supporting practice transformation in specific regions of the state, regional councils will be established (including providers, payers, purchasers, consumers, and policy-makers) and charged with facilitating the practice transformation process in their respective regions, convening providers and payers to consider how best to advance payment reform to support this new care model, and working with the region's stakeholders to assure that the implementation of the practice transformation and payment reform addresses health priorities recommended by the NYSDOH and the statewide steering committee.

3. **Continued Work with Payers and Purchasers:**

The State will continue to build on their efforts to better understand current payment methods for medical homes and other advanced primary care models, in an effort to enlarge and solidify the support of payers for advanced primary care, and value-based payments that recognize and adequately cover the costs of those new primary care models. This also includes continued efforts by the state to engage CMS and Medicare in multi-payer engagement efforts in New York. NYSDOH and NYSDFS will formalize payer participation by region and initiate practice transformation activities where adequate payer support of the APC model exists.

4. **Alignment:**

As the state prepares for the phased implementation of its statewide practice transformation efforts, there is an increasing need to align APC with the other medical home models that are already in the market or emerging. NYSDOH will continue its ongoing effort to align these

programs at the state governance level (DSRIP, PCMH/NCQA, APC, CPC+, MACRA), and increase efforts to develop clear communications regarding APC and its relationship to these programs.

5. Regional Oversight:

To augment the state-wide guidance, promote collaboration and facilitate progress throughout the state NYSDOH will model its regional approach after successful work being done in both the Finger Lakes and the Adirondacks regions. These regional committees will also assist in state supervision with respect to anti-trust legislation. There are three stages to operationalizing APC regionally:

- State 1: Establish Regions and Regional Oversight and Management Committees (ROMC)
- Stage 2: Activate Regions and Begin Meetings of the ROMC
- Stage 3: Engagement of Practices and Demonstrate Performance by Region

Figure 7. Regional Governance
Regional Governance



Regional Oversight and Management Committees (ROMC) will convene to:

- Resolve questions or concerns that arise in the region,
- Communicate with the Statewide Steering Committee on region-specific issues, and
- Ensure smooth implementation of the APC model within regional contexts.

Topics could include:

- Issues between TA entities and practices;
- Issues between payers and providers;
- Patient/consumer feedback;
- Best practices, lessons learned, and challenges;
- Regional linkages between clinical and community resources.



6. Strategies for Small Practices

NYSDOH, together with DFS, will work with provider professional organizations and other stakeholders to encourage the development of shared administrative service strategies to help these practices better meet required core metrics of APC and enter into value-based arrangements with multiple payers in a manner that they would otherwise find challenging on their own.

Challenges and Issues to Resolve

Implementing APC in a Diverse Primary Care System

One of the major challenges facing the implementation of APC across the state is the diversity of the primary care delivery system and the patient populations they serve. In addition to workforce shortages, regional nuances, and a vast array of practice business models, considerable focus was given to the future sustainability of primary care practices and the tension between rising practice expectations requiring investment in time, personnel, and technology and the limited resources of smaller practices. Stakeholders were active both on and behind the scenes to champion strategies and provide expert guidance on the seven APC Milestones and the technical specifications responsive to the needs and capabilities of primary care practices of all sizes. Important areas for consideration included goal-setting, leadership, workflow changes, and the development of organizational tools to improve outcomes within a more effectively integrated care delivery system. This is best evidenced by the approach to embrace transformation assistance as a viable and concrete support for the creation of sustainable care delivery change. Through the practice evolution over time represented in the three Gates of core practice competencies, state-contracted transformation agents will serve to assist clinicians in the challenging work of practice redesign required to be successful in value-based payment.

The APC model, like other primary care models, has a significant focus on more effective identification and management for patients with chronic, complex disease(s) and areas of care with high avoidable costs, both of which are more obvious and developed in adult populations. Milestones, and particularly core measures, leverage the calculation of the expected returns-on-investment for reducing preventable ED visits and admissions. Although these characteristics apply less often to the pediatric population, much of APC has applicability for pediatric practices and key pediatric prevention measures are represented within the core set of quality measures chosen for APC. Future consideration during implementation should be given to consider how, and in what ways, APC can better reflect the needs of children and adolescents/young adults and pediatric practices. For example, it was suggested that milestones and measures related to developmental screening, referrals to Early Intervention (EI) services, and maternal depression screening are important components to consider during model implementation and evolution for child and adolescent health care providers.

Payment

As noted above, there is substantial diversity in the models that health plans use for their payment reform initiatives with primary care clinicians. That said, payers are promoting and supporting many versions which align with the core features of APC (i.e., prospective, non-visit based payments, pay for performance/value, etc.). Some specific examples include the provision of care management payments, primary care capitation, bonuses, and shared savings, among others which may offer combinations of these approaches.

The diversity of payer-adopted models is something that must be recognized as representing the early stage of new payment approaches and the need for innovation absent a clear answer as to which approach is 'best'. That said, the ability of practices to effectively understand, engage, and be successful in a value-based payment environment with this degree of payer variation is an open question. It appears that, working to achieve greater alignment on core measures and expectations of primary care

practices (APC Milestones) along with agreement to move away from fee-for-service payments alone, may represent a sensible approach to advance both payer goals and practice needs.

The question of whether a ‘critical mass’ of payers are supporting APC has implications for practices and payers. Practices are concerned with whether there is both sufficient ‘signal’ and resources from payers to support advanced primary care services and payers are concerned about the possible ‘free rider’ impact from the non-participation of some payers. Clearly, this area of common ground between practices and payers will require joint and ongoing efforts to address and the solutions will be critical to the success of any payment and care reform efforts.

Finally, there is a need to address the problem of how low margin, low capital practices can afford the transition period in which they are providing new services and developing new infrastructure, performing work that is not currently paid for under fee-for-service, and simultaneously having to cope with the timing and uncertainty of potential retrospective ‘shared savings’ or other value-based payments, of equally uncertain amounts. This issue was partially addressed in the formulation of the APC model which proposed that practices reaching Gate 2 should receive augmented payments for care management, for a period of time to be able to achieve meaningful changes in quality, utilization and cost that will promote incremental revenues under shared savings or other value-based arrangements. This is a critical issue and one of particular importance to small practices, whose financial viability and/or ability to tolerate risk is most tenuous.

Behavioral Health

The APC model recognizes and includes the integration of behavioral health as an integral part of a transformed primary care practice. Existing models such as the Collaborative Care model – which includes use of a behavioral health care manager in coordination with a consulting psychiatrist using an organized data driven approach to meeting treatment goals – are being considered as viable evidence based approaches supporting the primary care provider in the delivery of integrated care shown to improve outcomes. Other similar models, more accessible to small and medium-sized practices are a focus of consideration in the APC milestone criteria. Several pilots are underway, but generating support and acceptance for models that are tailored to small and mid-sized practices, gaining acceptance for payment from health plans for behavioral healthcare in primary care practices, and aligning with other behavioral health integration models remain a challenge. To better support the integration of behavioral health in primary care, training and support from OMH for practice transformation entities will be available. NYSDOH and OMH will continue to coordinate to identify and develop strategies to expand behavioral health services, and address the issue of sustainable financing of behavioral health integration.

Ongoing Development of Measures and Outcomes

One of the signal achievements of the ICWG process was the delineation of a common set of measures for assessing the performance of APC practices. These measures are recognized to be ‘Version 1.0’ and in need of further refinement and development in the years ahead. There may be a need to adapt these measures for local needs responsive to the specific populations seen within individual practices. There is a need for a viable and timely feedback process related to APC model’s Milestones as well recognizing that new programs may generate continued challenges for practices (i.e., alignment with MACRA). A major inhibitor of measurement parsimony and alignment remains that each payer program targets different populations and/or incentive programs (Medicare Stars), and therefore the heterogeneity and

multiplicity of measures will likely remain a reality for payers and practices. Increasing alignment is a challenge that must be addressed however if the APC program is to contribute to assisting practices under great measurement burden to retain sufficient interest and resources to engage in improvement activities. NYSDOH will continue its efforts to align with other initiatives, and will participate in MACRA quality measure development through public comment and other opportunities to engage with CMS.

Similarly, work begun during the ICWG's deliberations on measures and standards for population health are an important contribution but require continued development for relevance, feasibility, and impact.

Careful consideration should be given to the implementation challenges and opportunities of data aggregation across payers, data integration of claims and clinical data, and the 'net result' of a confluence of requirements that impact providers and payers. The state should continue its work with providers and payers to finalize and implement a Scorecard that will provide the capacity to better understand and report data that meaningfully depicts the impact of the APC program on care delivery, outcomes and costs. This includes the capacity to report performance data back to providers in a meaningful, actionable way. Making use of stratified data for specific populations of interest will also enable the state, providers and payers to focus on patient level outcomes that advance our collective efforts towards reducing health disparities.

Design/Communication - Clinicians

The APC model is being implemented in a time when providers and payers are faced with significant fatigue related to 'new' initiatives. In addition to efforts to align and simplify wherever possible, it is also important to clarify that the success of APC is measured by improvements in health, health care delivery, and costs, , not simply the introduction of value-based contracting. Value-based payment (VBP) is not a goal that stands alone, unrelated to better patient outcomes or overall improvements in population health.

Design/Communication - Consumers/Patients/Families

From a design and communication perspective, it is important to accelerate awareness to patients and families regarding advanced primary care. In the course of implementation, being able to monitor the degree to which these services meet the needs of consumers and patients is of paramount importance. Further, success of implementation relies on patient/family engagement at the point of care, as a contributing member of health care organizations quality improvement programs, and through the provision of meaningful input as the APC model develops over time. For this to be maximally effective, consumers must have clear understanding of APC goals and how it relates to their care needs. Communications and marketing will be essential to help consumers understand this new model, how it may benefit them, and how they can be engaged in all the activities described above.

Alignment

Alignment has been a frequently discussed topic in the ICWG and for many of the reasons already described in this report, will continue for some time to be a top priority. There are many opportunities to work towards alignment:

- Identify opportunities of collaboration, support, and coordination among transformation initiatives (e.g., MACRA, NCQA, DSRIP, CPC+, etc.).

- More clearly align with DSRIP to promote population health, behavioral health, and primary care.
- Increase communication with providers, who are operating in a landscape of new initiatives, about the APC model, its benefits, and the availability of technical assistance to reach its goals.
- Initiate and/or facilitate regional conversations about APC and practice transformation to ensure that the model is operationalized in a way appropriate to the needs and context of the regional communities.
- Further engage providers and consumers in the activation of APC regions, and coordinate these efforts with DSRIP whenever possible and appropriate.

Workforce

The ICWG is mindful of the deliberations and goals of the Workforce Workgroup which is focused on ensuring a dependable supply of competently trained medical professionals. New York's robust health care workforce faces future challenges including regional variation in workforce supply, primary care workforce shortages, hospital downsizing, as well as an aging workforce. The SIM testing grant will continue to examine New York's educational and training institutions and their ability to adequately equip the State's workforce in the networked, team-based, value-driven, primary care-focused model of the future.

Health Information Technology

Health Information Technology and health information exchange is essential to transformation. Coordination of activities to implement APC will be reported and shared with the Transparency, Evaluation, and HIT Workgroup. Advances and implementation of HIT and new capabilities and initiatives like the All Payer Database are instrumental to supporting APC.

Conclusion

Under the State's SIM initiative, the ICWG has been extremely productive and effective in the development of the major components of APC. As the ICWG prepares to sunset and a new governance model begins, the NYSDOH, DFS, the Statewide Steering Committee, and local regional governance must continue the momentum to advance APC and help the State achieve its SHIP goals of achieving the Triple Aim for all New Yorkers.

Appendix

A. Integrated Care Workgroup Membership

Chairpersons	
Chair, internal:	Foster Gesten (NYSDOH/OQPS) Troy Oechsner (DFS)/John Powell (DFS)
Chair, external:	Susan Stuard
State team members	
Marcus Friedrich (NYSDOH/OQPS) Lloyd Sederer (OMH) Jay Carruthers (OMH)	Peggy Chan (NYSDOH/OHIP) Alda Osinaga (NYSDOH/OHIP) Barbara Wallace (NYSDOH/OPH)
Extended work group members	
<p>Providers: Tom Mahoney (FLHSA) John Ruge (HHHN) Van Dunn (HHC) Scott Hines (Crystal Run) Steve Rosenthal (Montefiore) Stephens Mundy (CVPH)</p> <p>Payers: Bruce Nash/Robert Hinckley (CDPHP) Bob LaPenna (Empire BCBS) Cliff Omstrom (United- Empire Plan) Paul Eisenstadt (Excellus) Susan Beane, MD (Health First) Dominick Bizzarro (MVP) Paul Macielak (NYHPA) Sean Doolan (BCBS Association)</p> <p>Professional Organizations: Sarah Shih (PCIP/NYCDOHMH) Linda Lambert (ACP) Elie Ward (NYSAAP) Joseph Maldonado (MSSNY) Vito Grasso (AFP) Ronda Kotelchuck/Louise Cohen (PCDC)</p> <p>Hospitals and Health Systems: Jeffrey Gold (HANYS) Bill Streck (HANYS) Kathleen Shure (GNYHA)</p>	<p>Behavioral Health: Virna Little (HealthConnect) Alan Wilmarth (UHS Binghamton)</p> <p>Population Health: Anthony Shih (NYAM) Greg Burke (UHF)</p> <p>FQHC: Diane Ferran (CHCANYS)</p> <p>Human Service Agencies: Steven Margolies(Phoenix House/Fidelis Care) Cathy Saresky (Catholic Family Center) David Woodlock (Institute for Community Living) Erik Geizer (NYSARC)</p> <p>Business: Jeremy Nobel (NEBGH) Laurel Pickering (NEBGH)</p> <p>Consumer Representation: Chuck Bell (Consumers Union) Elisabeth Benjamin (CSSNY) Kate Breslin (Schulyer Center)</p> <p>Foundations: David Sandman (NYS Health Foundation)</p>

B. ICWG Meeting Materials

All ICWG presentations and handouts are available online and were posted following each meeting. Materials are stored online on the following NYSDOH webpage:

https://www.health.ny.gov/technology/innovation_plan_initiative/workgroup_integrated_care.htm

C. SHIP Pillars and Enablers

Goal	Delivering the Triple Aim – Healthier people, better care and individual experience, smarter spending				
Pillars	<p>1</p> <p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way</p>	<p>2</p> <p>Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it</p>	<p>3</p> <p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable individuals and providers to make better decisions at enrollment and at the point of care</p>	<p>4</p> <p>Pay for health care value, not volume</p> <p>Rewards for providers who achieve high standards for quality and individual experience while controlling costs</p>	<p>5</p> <p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p>
Enablers	<p>Workforce strategy</p>	<p>A</p>	<p>Matching the capacity and skills of our health care workforce to the evolving needs of our communities</p>		
	<p>Health information technology</p>	<p>B</p>	<p>Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</p>		
	<p>Performance measurement & evaluation</p>	<p>C</p>	<p>Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</p>		