Project Narrative

Section 1: Plan for Improving Population Health

SIM funding is requested to extend the reach of NY's population health initiative, the Prevention Agenda 2013-2017 (PA)[1] by integrating PA activities with clinical care delivered under the Advanced Primary Care model proposed in this application to better achieve strategic outcomes. NY's PA, created by a diverse set of stakeholders including local health departments, health care providers, health plans, community based organizations, academia, employers, state agencies, schools and businesses, has five priority areas: (1) Prevent Chronic Disease; (2) Promote Healthy and Safe Environments; (3) Promote Healthy Women, Infants and Children; (4) Promote Mental Health and Prevent Substance Abuse; and (5) Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare Associated Infections. Each priority area identifies goals and indicators to measure progress and recommended policies and evidence based interventions using the National Prevention Strategy and other sources.[2] PA goals have been integrated into both the State Health Innovation Plan[3] (SHIP) and the State's Medicaid waiver (DSRIP),[4] and progress on achieving goals is measured using a dashboard.[5] Oversight of the PA and the SIM Population Health initiative will be under the jurisdiction of NY's Public Health and Health Planning Council.[6] This Council will be part of the overarching SHIP governance structure, will serve as the Population Health workgroup convened to oversee

[1] https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/
[2] The PA uses the health impact pyramid as the organizing framework for each priority specific action plan, described in Frieden, TR. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health April 2010;100(4); 590-595.
[3] https://www.health.ny.gov/technology/innovation_plan_initiative/
[4] http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program
[5] https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard
[6] http://www.health.ny.gov/facilities/public_health_and_health_planning_council/

relevant SIM funded initiatives and will ensure integration and alignment of the PA, DSRIP and the SHIP.

SIM funding will broaden the focus of the PA to support the delivery of clinical preventive services that have a demonstrated impact on PA goals and strengthen linkages between clinical care providers, local public health and community based organizations. Support and education on these expanded clinical prevention services will be provided by SIM-funded Public Health Consultants (PHCs). These consultants will work closely with regional Population Health Improvement Programs (PHIPs), SIM-funded practice transformation teams (described in Section 2) and Medicaid DSRIP Performing Provider Systems. PHIPs are newly funded regionally-based state entities (11 regions) charged with promoting the Triple Aim by convening key stakeholders to measure health and well-being and provide a neutral forum for identifying, sharing, disseminating and implementing best practices to promote population health.

Examples of PHC-supported clinical initiatives include: promoting tobacco dependence treatment for persons with mental illness; implementing evidence-based health system changes for persons with diabetes, asthma and hypertension through population registries, team-based care and bi-directional referrals to community based services; and integration of preconception and inter-conception care for women of reproductive age. The target interventions address the most significant health challenges faced by NY[7] including tobacco, obesity, diabetes, HIV, poor maternal and health outcomes and mental health. The PHCs will connect clinicians with community-based programs such as Healthy Neighborhoods aimed at helping populations at

[7] Data on morbidity and mortality for NYS may be found in the States' Health Assessment, conducted in 2012 to identify the PA priorities and to establish PA indicators monitored regularly via the PA Dashboard. http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/background.htmhttp://www.health.ny.gov/prevention/prevention_agenda/2013-2017/background.htm

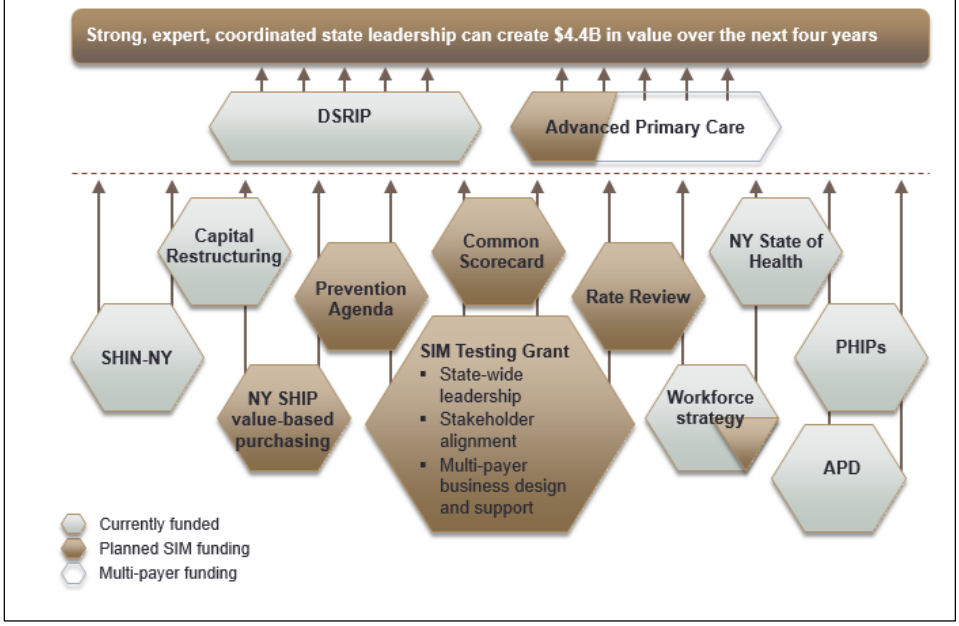
highest risk of housing related health issues like asthma. PHCs are key to achieving population health by reaching beyond clinical settings to incorporate community and public health systems.[8]

The PHCs will be managed by a newly appointed, SIM-funded Director of Health Systems/Public Health Integration working within NY's Innovation Office. Sustainability will be assured through ongoing support of key population health interventions by DSRIP, delivery system transformation, payer support of proven effective services (tobacco cessation) and potential hospital investments in community benefits as required by the Affordable Care Act.[9]

Section 2: Health Care Delivery System Transformation Plan

NY's health care delivery transformation plan, as articulated in the SHIP[10] is built on five pillars and three enablers.[11] The SHIP, recognizing that lasting health delivery system reform requires a high-performing primary care system, proposes statewide implementation of an enhanced medical home model, "Advanced Primary Care" (APC). It also

Figure 1: The SIM Testing Grant will spur innovation and catalyze change



[8] Hacker, K, Walker, D. Achieving Population Health in Accountable Care Organizations. American Journal of Public Health April 2013; 103; 1163-1167.

[9] NY has encouraged and is tracking hospital investments in community benefit tied to the PA. In 2010, $166m was spent on community health improvement. See: Achieving the Triple AIM in NYS: The Potential Role of Hospital Community Benefit. NY Academy of Medicine, 6/2014.

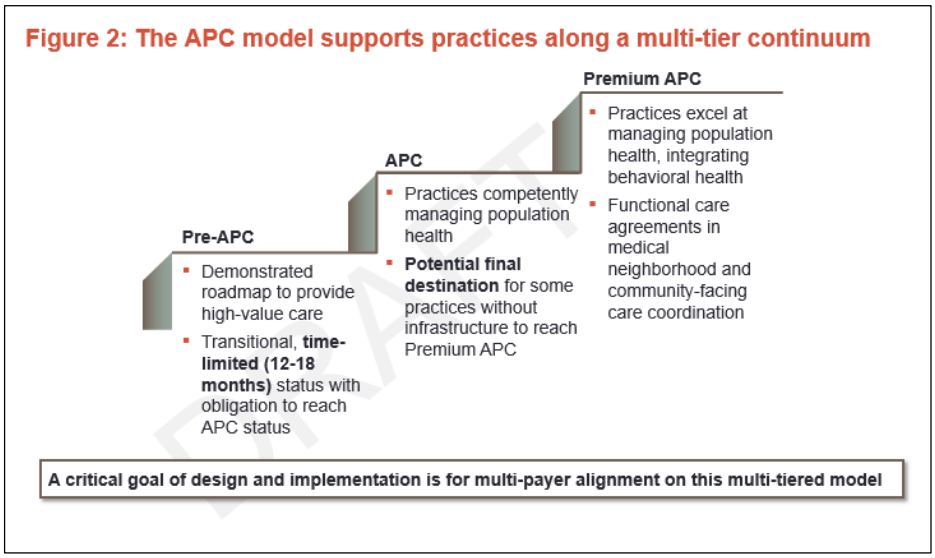
[10] https://www.health.ny.gov/technology/innovation_plan_initiative/

[11] http://www.health.ny.gov/technology/innovation_plan_initiative/docs/strategic_pillars.pdf

recognizes that coordination and integration of ongoing initiatives is key to long term success (Figure 1).

NY's APC model (Figure 2) is consistent with principles of NCQA Patient Centered Medical Home (PCMH) criteria, but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes. APC seeks to provide patients with access to high quality, integrated care, delivered by teams of providers with the capacity to manage the care of patients with chronic illnesses.[12] SIM support will enable the State to achieve three core objectives within five years:

Figure 2: The APC model supports practices along a multi-tier continuum



1. 80 percent of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare;
2. 80 percent of the care will be paid for under a value-based financial arrangement; and
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

Findings in NY and nationally suggest that a system with a medical home model at its heart will achieve the Triple Aim. Thus, NY is proposing initiatives to create more rational, patient-

[12] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998;1(1):2-4

centered care for all New Yorkers. SIM funding is requested to support the following: (1) APC model development leading to practice transformation support; (2) programs to ensure an adequate workforce; (3) a common scorecard to align measures across payers and providers; and (4) population health initiatives to align clinical care and CDC- and PA-endorsed strategies (see Section 1).

NY's plan builds on successes to date and incorporates lessons learned from an extraordinary range of initiatives, including the Aligning Forces for Quality (AF4Q) and Beacon Community initiatives in Western NY; a large number of payer-supported medical home projects, including two regional, multi-payer medical home initiatives; and CMMI-funded Innovation initiatives (including the Finger Lakes HSA's Innovation Award). NY's Medicaid program has provided early leadership and ongoing support for the medical home model by including a major initiative to implement medical homes in the state's hospital teaching clinics, and, most recently, the DSRIP. NY's APC model will be structured to support integrated delivery systems that link with NY's model health home program and with community-based providers that support health through services such as housing, transportation and employment.

New York's APC model is structured to promote enhanced access and reliable delivery of the chronic care model,[13] complemented by a value-based reimbursement structure and supported by strong analytics and a well-trained workforce. NY has led the nation in the adoption of the medical home model and the APC model builds on the State's strong base. As of July 2013, nearly 5,000 clinicians (25% of total primary care physicians) in NY were working in practices recognized by the National Committee for Quality Assurance (NCQA) as PCMHs. Federally

[13] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998; 1(1):2-4.

Qualified Health Centers in NY have achieved notable success with 80 percent of FQHC networks having achieved some level of PCMH certification. However, three-quarters of all primary care practitioners in the state work do not yet work in PCMH recognized practices.

SIM represents an opportunity to leverage investments made to date to assure broad adoption of an APC model inclusive of behavioral and population health, coupled with a strong workforce and educated and engaged consumers, supportive payment and common metrics. NY's proposed APC model uses a tiered approach that recognizes a continuum from non-integrated, fee-for-services practices with little experience with team-based care to highly evolved practices with well-functioning electronic health records and highly integrated team-based care that are better able—or already do—assume some level of shared risk payments. Over the coming year, NY will, with expert external stakeholders including NCQA and the Joint Commission, complete the design and implementation of a multi-tier APC model (Figure 2).

To support practices in the evolution to APC status, NY is proposing that $5M support creation of an APC model that achieves an ideal blend of consistency and flexibility and $67 million support practice transformation defined to include goal-setting, leadership, practice facilitation, workflow changes, measuring outcomes, and adapting organizational tools and processes to support new team-based models of care delivery. Practice transformation support would be predicated on an initial evaluation of practice readiness (7,642 practices) with average support of ~$50,000 per practice (all payers) over the three year implementation period or about $20,000 annually. This funding would complement DSRIP funding (targeted to safety-net practices) to assure support across payers and providers and promote alignment and consistent messaging.

Locally Driven Practice Transformation. The depth of contextual knowledge and deep

commitment of regional partners (Adirondacks, Finger Lakes, NYC, etc.) suggest locally driven practice transformation. SIM funding is requested to support regional practice transformation entities selected through a competitive procurement. Selection criteria will include experience, regional familiarity, ability to quickly evaluate practice readiness and deliver assistance promptly, and ability to work with the State and CMS and to gather and report metrics to evaluate components of success. NY will develop a standardized tool to assess practice readiness and create a statewide model curriculum to guide transformation efforts.

Primary Care Workforce. NY's robust health care workforce faces future challenges including regional shortages, primary care workforce shortages, hospital downsizing and an aging workforce. The State will examine the ability of its educational and training institutions to adequately equip its workforce in the networked, team-based, value-driven, primary care focused model of the future. The State proposes several initiatives to support the new APC model including the following:

1. *Identification of clinical and non-clinical gaps and needs specific to primary care, behavioral health, oral health, pharmacy and other areas needed to support the APC model and development of recommendations* through a workgroup inclusive of leaders in education and health care.

2. *Identification of mechanisms to increase the number of primary care residencies within the State*, particularly in primary care Health Professional Shortage Areas.

3. *Modification of Admission Criteria* – NY will explore possible policy levers such as a requirement that medical schools set aside a certain percentage of their slots for individuals who commit to primary care practice and/or consider geographic location, educational background and interest in primary care as admission criteria.

4. *Identification of opportunities to increase the number of active Nurse Practitioners and Physician Assistants working in primary care* (currently less than 1/3 of active NPs and about 1/4 of PAs work in primary care).

5. *Exploration of scope of practice* to assure all health professionals are working at the top of their license consistent with IOM recommendations.

6. *Development of tools to increase retention of physicians trained in NY*. NY currently retains only 45% of all residents trained in the State. NY will work with regional provider networks (teaching institutions, insurers, community health centers, and hospitals) to establish community incentives to recruit and train nurses and residents, promote a diverse provider workforce and address issues of cultural competency and health disparities.

Common Scorecard. The State will develop a scorecard as described in Section 7.

Sustainability and Replicability. Work under this grant will support testing of the proposed payment and delivery models; creation of a business case for integrated care and value-based payment; and capacity-building to support integrated care utilizing evolving health information technologies and a move to value-based payment. In collaboration with stakeholders and policymakers, we seek to move all primary care providers in NYS to an APC level, to align ongoing efforts and assure consistency in message and incentive.

Section 3: Payment and/or Service Delivery Model

New York's health care spending overall and per capita are among the highest in the nation. Outpacing both inflation and overall economic growth, the rising cost of health care has far-ranging consequences for wages, employment, the price of goods and services, and the ability to fund other public services. Achieving the triple aim requires implementation of innovations like the APC model, which have the potential to improve the performance of the health care delivery

system, improve health and well-being and reduce the total cost of care.

NY proposes, under the SHIP, to evolve payment for APCs from strictly FFS to value-based reimbursement to ensure consistency of incentive across providers and payers. NY's plan for shifting towards value-based payment includes: (1) Developing a flexible framework for APC payment that reflects start-up and longer-term costs, and providers' varying ability/interest in assuming risk, and; (2) Pursuing value-based payment broadly, embracing a range of approaches to connect payment to process and outcome measures, for all payers (including Medicaid, commercial, and the state employees' health insurance plan); and aligning regulatory processes to support and promote value-based payment.

Paying for APC: NY has substantial experience with value-based payment for primary care, based on the early and ongoing support of the PCMH model through its Medicaid program, and its involvement in medical home demonstrations in a variety of settings across the state. As these initiatives have progressed, it has become clear that transformation of primary care practices to an APC model will include three broad phases, during which the practices require different types of financial support as follows:

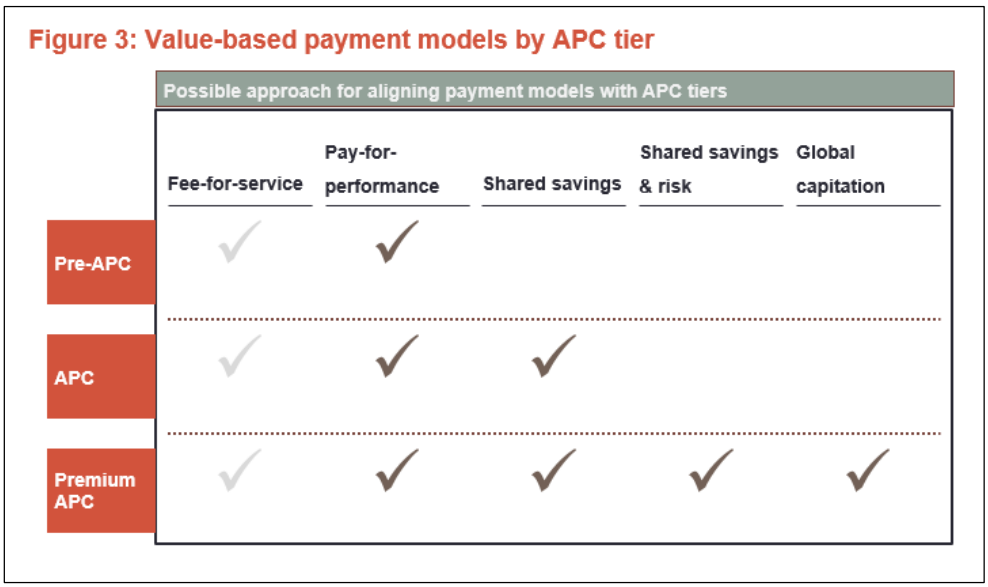
1. Initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff (or re-training existing staff).
2. Support for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support 'shared savings' payment. In the early years of the APC's operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not (yet) generating cost savings.
3. Ongoing support. Once the APC model has begun to have a measurable impact on total cost

of care and to generate measurable savings, the practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

Projects in NY have dealt with these costs differently. In the Adirondacks Multi-payer Advanced Primary Care Practice (MAPCP) demonstration, participating payers invested in practice transformation, making time-limited up-front investments on a PMPM basis to cover operating costs of the medical home model, including care management, transitional care, and the active use of data to improve care. Over time, payments in that program migrated to include Pay-for-Performance (P4P) incentive payments, and may in the future include shared savings.

In the State's other large multi-payer demonstration, the Capital District-Hudson Valley Comprehensive Primary Care initiative (CPCi), payers provided primary care practices with direct practice transformation support, or supported upfront care coordination fees, and offered practices opportunities for gain-sharing from the outset.

Figure 3: Value-based payment models by APC tier



Given these varied experiences, a multi-tiered APC structure reflects providers' varying ability and desire to move away from fee-for-service reimbursement. To assure long term success, a spectrum of options will be available to link payment to level of APC achieved that includes but is not limited to P4P, shared savings, bundled payments and global capitation (Figure 3).

Value-based payment: NY seeks to achieve value-based payment for 80% of the state's citizens. To achieve this, NY will first evaluate the current extent of value-based payments and then work with Medicaid, commercial insurers, business and the self-insured to develop, promote and implement value-based strategies including value-based insurance design (VBID).[14] More specifically NY will:

(1) Define the landscape. NY is working with the Catalyst for Payment Reform (CPR)[15] to evaluate the range of payment mechanisms now used by payers and Medicaid in NY. This work, supported by a NYS Health Foundation award, will produce the first-ever comprehensive (public and private payers) statewide scorecard on payment reform. CPR will identify the percentage of NY health care expenditures that are paid using fee-for-service and alternative payment methods and disseminate findings by April 2015. This information will guide efforts to achieve the SHIP's goal of 80% of all payment to be value-based within five years and the Medicaid DSRIP goal of 90% value-based payment.

(2) Create a Common Framework and Strategy for Action. NY will partner with the Northeast Business Group on Health, a network of employers, providers, insurers and other organizations working together to improve the quality and reduce the cost of health care in New York, New Jersey, Connecticut and Massachusetts, to create a common agenda and plan of action to improve care, reform payment, and align measures and benchmarks. SIM funding is requested to support the following: (a) Creation of a statewide payment reform committee inclusive of business, employers, payers and providers charged with creation of an overall

[14] The Department of Financial Services conducted a payment reform survey in 2013 as a baseline: http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf
[15] http://www.catalyzepaymentreform.org/

strategic framework and goals that align initiatives and payers. This workgroup will report to the Integrated Care workgroup (see Section 6) and will utilize the CPR payment reform scorecard to identify gaps and create an action plan to inform statewide policy; and (b) convene regional employers, business, insurers, and providers to address region-specific attributes and challenges and achieve alignment within the statewide vision/framework.

Section 4: Leveraging Regulatory Authority

The State is prepared to use the following regulatory levers to achieve transformation:

1. Create a common quality scorecard and standard reporting requirements for payers and providers;
2. Support value-based payment models and benefit design, as part of the rate review approval process;
3. Promote VBID as part of subscriber contract review;
4. Continue to promote transparency to inform consumers, providers and payers;
5. Explore tools and policies to assure a robust primary care workforce including modifications to medical school admission criteria; mechanisms to increase the number of NPs and PAs in primary care and exploring scope of practice;
6. Require Medicaid Managed Care Organizations to adopt value-based payment with a goal of 90% of payments non-FFS within five years;
7. Require safety net providers to create integrated delivery systems including increased certification of primary care practitioners with PCMH and/or APC through DSRIP; and
8. Support APC adoption by Qualified Health Plans.

Using Regulatory Authority to Promote Value. The NYS Department of Financial Services (DFS) is statutorily charged with reviewing and approving health insurance premium

rates and has an effective rate review (ERR) program as determined by HHS in July 2011. DFS has oversight of premiums for 64% of all commercially insured lives or 6.3 million lives (32% of all lives in NY). Following a rigorous review of rate review practices, guidance, and regulatory measures implemented by other states, NY identified the following as possible initiatives:

a. Promote Value-Based Models and support of APC: Data from a recently conducted survey by DFS shows that a majority of payers are piloting new payment models. Established targets for value-based models could be used as part of Rate Review to promote and support value-based payment and the APC model.

b. Set Annual Medical Expenses Growth Benchmark: NY is exploring the possibility of using guidance to be considered as a benchmark on growth. The exact calculation of this target will need further discussion and stakeholder input. The State is taking note of the methods used by Massachusetts (use of GDP growth rate) and NY Medicaid (10-year rolling average of CPI for Medical Care).

c. Integrate quality of care information into the rate review process: The Department of Health has a 20 year history of measuring the quality of care provided by major insurers doing business in the state. Results are published annually and disseminated widely.[16] Later this year NY intends to adopt CMS's five star rating system used to describe quality of care in the Medicare program to further align and simplify the information that is available to consumers, policy makers and providers. NY will explore ways to use this information when working with insurers to promote quality and value.

d. Create Tiered Network Incentives: Provide a mechanism for health plans to provide

[16] http://www.health.ny.gov/health_care/managed_care/consumer_guides/nyc/commercial_hmo/

incentives for members to use lower-cost, comparable quality providers and services.

Value-Based Insurance Design. NY is embarking on multiple efforts to align financial incentives to assure that providers, payers and consumers achieve optimal health at a reasonable cost. For example, NY Medicaid is using VBID as a key means of promoting value by encouraging rational insurance design. The NY State Employee Health Insurance Program will transition to a VBID benefit for a select group of state employees in 2015 and has engaged A. Mark Fendrick, MD, and his team at the VBID Center at the University of Michigan to assist. Target groups include employees with diabetes, asthma and hypertension identified from a total group that includes 12,900 NYS Management/Confidential and unrepresented enrollees, 40,000 retirees and 41,000 dependents. NY, with the University of Michigan and Health Research, Inc., submitted an application to the Patient Centered Outcomes Research Institute (PCORI) to support the evaluation of this new benefit offering.

As part of the SIM grant, the State requests funding to continue to engage with the VBID Center to better understand the impacts of this program and build an evidence base on the potential of VBID across the full State employee and retiree population. In addition, DFS will actively promote VBID benefit design for all commercial insurers using authority available as part of subscriber contract review.

Future Considerations. All work related to value-based payment will reflect early consultations (2014) with stakeholders which identified the following:

1. Enhanced primary care payments must be linked to primary care goals;
2. Health plan administrative costs must be considered;
3. Administrative simplification of APC for all plans' attribution, payment and reconciliation through automated processes is key to success;

4. Value-based payment models must be standardized to minimize conflicts in dealing with multiple payers; and
5. Special attention should be given to value-based model pilots underway, with the most successful pilots being used as a template in scaling the APC model across the state.

Section 5: Health Information Technology

Governance. Since 2006, NY has led the nation in investments in health information technology, including $400M through the Health Care Efficiency and Affordability Law of New York (HEAL-NY), $400M in private sector matching funds and $100M in federal funding. The New York eHealth Collaborative (NYeC), the State Designated Entity, is creating a statewide health information exchange to connect electronic health record systems at individual/group providers around the state. This ground breaking work is critical to success of the SHIP and will support APC providers, payers and consumers to promote value-based care and delivery, to coordinate across sectors and providers and ultimately to improve health through more efficient use of health resources.

NYeC facilitates the governance of the State's health information exchange, the Statewide Health Information Network of NY (SHIN-NY), through several committees that include stakeholders from hospitals, RHIOs, HIEs, healthcare practices, and more.[17] The governance model includes multiple stakeholder committees involved in the Statewide Collaboration Process – an open, transparent, consensus-driven process to develop policies, standards, protocols, and technical approaches to protect the public's privacy and security.[18] In addition, consumer and provider focus group forums are planned to capture the opinions of a broader audience.

[17] http://nyehealth.org/what-we-do/
[18] For example, privacy and security policies: http://nyehealth.org/wp-content/uploads/2012/06/Working-Policy-Committee-Edits-to-SHIN-NY-Privacy-and-Security-PPs.pdf

Policy. New York is targeting six levers to improve transparency, increase consumer engagement, and empower providers, payers and purchasers with the information they need to help achieve the Triple Aim: (1) Deploy a New York State consumer transparency portal; (2) Create a patient portal; (3) Complete implementation of the SHIN-NY; (4) Create and implement an all payer database (APD); and (5) Increase data availability to enable third-party innovation in transparency tools. New York's 2014-2015 State Budget included significant funding for several HIT resources, appropriating a total of $65 million including $55 million to support the SHIN-NY and $10 million for the APD, which will serve as a repository for health care utilization and spending data used to evaluate the performance of the health care delivery system.

Infrastructure. NY's robust health information infrastructure includes a first in the nation SHIN-NY and an APD to assure an effective platform for sharing critical clinical information among doctors and patients and detailed claims information that will be used to promote quality and assure value. In addition, NY is about to launch a Patient Portal which will allow patients simple, secure online access to their personal health information, via the SHIN-NY. The patient portal will permit individuals to review the details of their health records and medical history in a manner that assures privacy by making this information available only to those granted access.

The SHIN-NY supports NY's broader health care goals of improving the outcomes, quality, efficiency, and cost of health care. The SHIN-NY will allow clinicians and consumers to make timely, fact-based decisions that will reduce medical errors and redundant tests and improve care coordination and the quality of care. It will also facilitate team-based care to promote efficient and effective care delivery, inclusion of behavioral health and links with population health.

NY's robust open data initiative (Health Data NY),[19,20] recognized with the national Data Liberation Award in 2013,[21] provides numerous data,[22] including on discharges, costs, charges, PA, prevention quality indicators and potentially preventable admissions. The State is expanding upon the types and formats made available quickly through an evolved patient-friendly, hospital quality website and publication of health insurance data through a CMS-funded Cycle III grant to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing.

Technical Assistance. NYeC and NYC REACH provide technical assistance with EHR Adoption; Workflow Redesign; Quality Improvement; Incentive Programs; PCMH; PQRS; and Meaningful Use. Over 10,000 providers—small independent practices, community health centers/FQHCs, Health Homes, hospitals and clinics—received EHR and Meaningful Use assistance. As a result, over 500 sites have PCMH recognition; over 7,000 are Meaningful Users; and over 15,000 behavioral health providers have adopted EHRs and care coordination software. These efforts will be extended to providers as needed through APC transformation support.

Section 6: Stakeholder Engagement

NY has a long history of partnering with external stakeholders to develop key policy recommendations. The Medicaid Redesign Team (MRT), which recommended more than 200 initiatives to implement programmatic changes to the way health care is provided, reimbursed and managed, included 25 voting members appointed by the Governor including: state officers or state employees with relevant expertise; members of the New York State legislature, leaders with

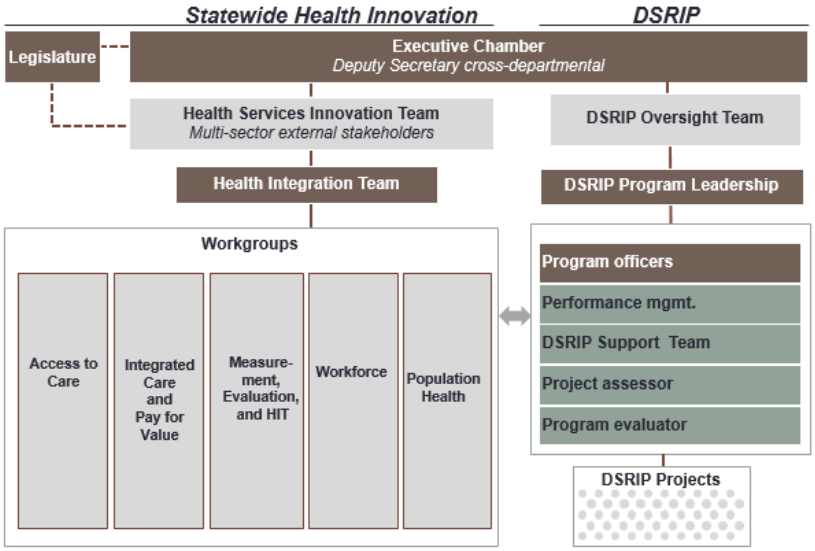
[19] https://data.ny.gov
[20] https://health.data.ny.gov/
[21] http://www.health.ny.gov/press/releases/2013/2013-06-04_datapalooza.htm
[22] Health Data NY currently has 309 Data Views. A summary of the various Data Views includes: 75 Datasets which have all of the platform functionality (APIs, visualizations, embeds); 130 charts that are associated with datasets to provide public health messages and promote proper use of data; 39 maps that are associated with datasets; 6 Filtered views are done to highlight a subset of data; and 38 Files and Documents which are zip files with all of the meta data and data file.

expertise in the healthcare industry; leaders with expertise in the healthcare insurance industry and business and consumer leaders.

NY will follow a similar model when implementing the SHIP. In fact, NY reached more than 60 organizations representing health care providers, business, consumers and payers during development of the SHIP and more recently in drafting the SIM grant application. Similar to the successful MRT model NY will create an overarching policy team along with five topic specific workgroups. The overarching team, the Health Services Innovation Team, comprised of external stakeholders will report to the Governor. Each of the five workgroups will be co-chaired by a state leader together with an external expert and will include external stakeholders selected for their expertise, vision and input.

External stakeholders to be engaged include will include representatives of the following:[23] Health Plans, businesses and employers; hospitals, medical societies, consumers, behavioral health providers and academic medical centers.[24] The Health Integration Team noted in Figure 4 reflects a novel approach to system redesign that brings together staff of the Departments of Health, Financial

Figure 4: New York's Statewide Health Innovation Governance



[23] The organizations listed were involved in the SHIP design and development of the SIM application for funding.
[24] This list is illustrative only and is not exhaustive as space constraints preclude listing all involved stakeholders.

Services, Civil Service, Mental Health, Alcoholism and Substance Abuse, Education and the Division of the Budget.

Administrative and programmatic support for this initiative will be provided through a Health Innovation Office that spans multiple agencies and the Executive Chamber of the State of New York. Participating agencies will include: Department of Health, Department of Financial Services, Department of Civil Service, Office of Mental Health, Office of Substance Abuse Services, and Office for People with Developmental Disabilities, and Division of the Budget. Finally, the alignment of the Health Services Innovation Team and the DSRIP Oversight Team, is essential for success for transformation care across all NY, including both commercial and public payers.

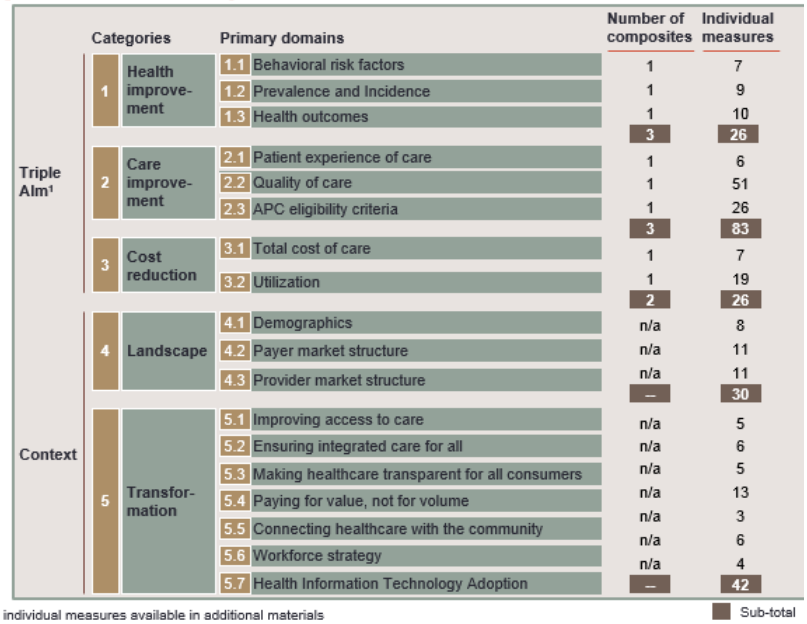
Section 7: Quality Measure Alignment

A comprehensive and systemic set of indicators that can be used across payers, providers and regions of the state will be developed that reflects nationally recognized measurement approaches—such as Healthcare Effectiveness Data Information Set (HEDIS), National Quality Forum (NQF), and Children's Health Insurance Program Reauthorization Act—to allow benchmarking to national results.

In addition to measuring performance improvement at the provider, practice and payer level, the State will comprehensively evaluate system transformation in order to ensure a strong trajectory toward our system level goals: achieving top quartile performance among states in prevention and public health; greater than 20 percent improvement in avoidable admissions and readmissions; and 2 percent annual cost reduction against trend resulting in $5-10 billion in cumulative savings over 10 years.

The State, through collaboration with stakeholders, developed a first draft of a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivery—a common scorecard. This core set of industry-standard metrics will serve as a common basis for measuring progress and impact of the SHIP including the new APC model. Existing metrics from the MRT, health plans, and hospitals provided the basis for this approach and will be augmented and triangulated with selected metrics from the PA, multipayer Primary Care demonstrations such as CPCi, the MAPCP Demonstration and other industry standards.

Figure 5: The draft scorecard includes 5 measurement categories, 18 primary domains, 8 composite scores, and 207 individual measures[1]



New York's rigorous first draft of a proposed 'standard scorecard' (Figure 5) is based on industry standards and includes 5 measurement categories, 18 primary domains, 8 composite scores and 207 individual measures. The final set of measures will be determined with input from key stakeholders over the coming months and then published as the statewide standard. To encourage statewide adoption, these will be the measures supported by the State-led HIT infrastructure and standardized reporting, and will be used as the basis for all Medicaid and the NY State Employee Health Insurance Program contracts and for increasing use in commercial contracts. Importantly, these measures will evaluate important dimensions of quality including

outcome-linked processes, health outcomes, utilization, patient experience and efficiency.

The State will measure performance and improvement at the provider, practice and payer level, to ensure a strong trajectory toward our system level goals: achieving top quartile performance among states in prevention and public health; greater than 20 percent improvement in avoidable admissions and readmissions; and 2 percent annual cost reduction against trend resulting in $5-10 billion in cumulative savings over 10 years.

To promote implementation and use of the common scorecard for quality improvement, the State will be requesting funding from SIM to support the NYS Quality Institute, a public-private partnership created under the auspices of the United Hospital Fund as a neutral, trusted convener with the capacity to bring Quality Improvement experts and stakeholders from across the continuum of care together to generate ideas, initiatives, and consensus. The Quality Institute will support and promote collaboration and organizational change necessary for alignment and adoption of quality metrics.

Section 8: Monitoring and Evaluation Plan

Robust measurement and evaluation of the State's progress toward achieving the Triple Aim will be critical at all levels—State, payer, community, provider, and consumer. To this end, the State has shown the initiative to standardize measurement processes and to invest in data systems that improve measurement and analysis. In addition the State will contract with external evaluators during 2015 to assure model implementation is conducive to meaningful monitoring and evaluation.

The SHIP evaluation plan will include the core set of Quality of Care Measures, Efficiency Measures and NY Population Health Indicators. These indicators will be used to monitor the SHIP's progress toward its performance goals over the next decade. The measurement strategy

of the SHIP will build on national standards, state level experience and will result in a common approach.

The capacity to capture data necessary for the monitoring and evaluation is currently being developed and implemented. In synergy with the development of the APD, the New York State Department of Health (DOH) has begun to expand current measurement capabilities to include not only managed care recipients but all Medicaid recipients. In order to reduce burden to providers and operationalize the calculation and aggregation of quality measures at various levels, the DOH has partnered with an information technology company under contract with the NY's Medicaid Data Warehouse (MDW) to implement a clinical data table using Medicaid claims, encounters, and member information. For the measures which could be programmed using administrative data, the contractor is creating an automated monthly process using the MDW to build a clinical data table. The table will contain member-level information for each quality indicator using the measure specifications applied to the entire Medicaid population using a rolling-12 month period. All measure denominators and numerators, along with enrollment, eligibility, and optional exclusions will be created monthly for a rolling year, and annually for a calendar view, of the measures that can be programmed administratively. The resulting quality indicators will be applied to all Medicaid adults, be available to a broader audience, and allow integration of quality data with other analyses in a consistent and accurate manner. The result will be quality indicators available to a broad audience and will allow integration with other analyses in a consistent and accurate manner as well as the ability to do more rapid-cycle improvement strategies and regular monitoring of quality measures before and after interventions are put into place. This project will provide much of the foundation and groundwork that will be needed to build an APD in NY that will be able to meet the goals of the SHIP.

Furthermore, ongoing HIT development reinforces the capacity for statewide measurement and reporting. Both the APD and SHIN-NY will allow for accelerated data collection, aggregation, and analysis. In addition to using transactional data, NY has begun capturing quality data from providers using their EHRs. NY's Medicaid EHR Incentive Program Administration system (MEIPASS) allows providers participating in an incentive program for EHRs to report aggregate data for several quality indicators. A portal system is also in planning stages that will be used to share information with providers and to collect clinical quality data that will be maintained in a repository which will be linked with the clinical data table. The DOH is creating both the clinical data table and the EHR repository to be used in various attribution models allowing aggregation by provider or community. The DOH has gained experience with attribution in quality measures with evaluation of PCMHs and health home models.

Population health indicators, based on the PA, will be integrated with efficiency measures and quality measures to allow monitoring of the Triple Aim at all levels of health care, from providers to statewide.

Information from the systems will be used to provide ongoing feedback to providers and stakeholders including consumers, about the quality of care as the SHIP progresses. Public reporting will be enabled through the future Patient Portal and Cycle III transparency website for system and provider quality and cost performance.

External evaluators will ensure that the capacity and data are able to be structured and aggregated accurately to provide a solid foundation to evaluate progress toward SHIP goals.[25] In addition, the evaluator will review and advise on the long-term priorities of evaluation and the

[25] As described in the SHIP's Driver Diagrams:
http://www.health.ny.gov/technology/innovation_plan_initiative/docs/driver_diagram.pdf

comprehensiveness of data to ensure evaluation goals will be met in ten years.

Section 9: Alignment with State and Federal Innovation

NY's SIM will align with and build upon numerous Medicare and Medicaid demonstration programs including ACOs, the nation's largest local CMMI Innovation Award initiative in the Finger Lakes region, as well as the Capital District-Hudson Valley's CPCi efforts, MAPCP Demonstration in the Adirondack region, FQHCs and the Primary Care Information Project (PCIP) in NYC, The proposed model builds on and integrates with existing priorities and innovations including NY's MRT Waiver (DSRIP) the NYS PA 2013–2017; the NCQA and the CPCi provider participation standards.

Coordination with Medicaid is critical. The State's Medicaid program is the single largest health insurance program in the state, spending more than $54 billion annually to provide health care to more than 5.4 million eligible individuals. Effective April 10, 2014, CMS approved NY's request for a Medicaid waiver amendment to the existing 1115 Partnership Plan. The centerpiece of the waiver amendment is the creation of the DSRIP Program which seeks to reduce avoidable hospital use and emergency department use by 25% over the next five years; move to a more integrated care delivery system that includes the APC model and move away from fee-for-service – components that align well with and will be integrated with the SHIP as it evolves.

The Medicaid-based PCMH Incentive Program and the Hospital-Medical Home Demonstration are current examples of significant investments in primary care for Medicaid enrollees in NY. These large initiatives will both inform, and be guided by, the SHIP. Each of these initiatives will be integrated as the SHIP is implemented. Representatives of each of these initiatives participated in the development of the SHIP and provided input into this application. and will be invited to participate as members of the Integrated Care and Pay for Value workgroup

to ensure learning, sharing and collaboration.