New York State Health Innovation Plan

December 2013

NEW YORK state department of HEALTH

New York State Office of Mental Health

OASAS Improving Lives.

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Executive Summary

New York's State Health Innovation Plan (hereafter "the Plan") is our roadmap to achieve the "Triple Aim" for all New Yorkers: improved health, better health care quality and consumer experience, and lower costs. We seek to achieve this through a multi-faceted approach that has at its heart an advanced primary care model that integrates care with all parts of the health care system, including behavioral health and community-based providers and aligns payment with this care model.

Over the past several years, New York has been a thriving incubator of health care innovation. New models for payment and care delivery, focused on delivering the Triple Aim, have been spearheaded by physicians, health systems, and other providers, with the active support of multiple consumer groups, our business community, as well as Medicare, Medicaid, the New York State Health Insurance Program (NY-SHIP), and more than a dozen private health insurers operating in the State. We have many individual success stories to celebrate. Our Plan builds on this significant experience, while sharpening our focus and aligning efforts going forward in order to bring innovations to scale.

Our goals for this Plan are ambitious. We aspire to:

(1) achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement within five years;

(2) achieve high standards for quality and consumer experience, including at least a 20 percent reduction in avoidable hospital admissions and readmissions within five years; and

(3) generate $5 to $10 billion in cumulative savings by reducing unnecessary care, shifting care to appropriate settings, and curbing increases in unit prices for health care products and services that are not tied to quality, within five years.

New York State will achieve the Triple Aim within 5 years

	Goal
Improved health	*Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement.*
Better health care and consumer experience	*Achieve high standards for quality and patient experience, including at least a 20 percent reduction in avoidable hospital admissions and readmissions.*
Lower costs	*Generate $5-to-10 billion in cumulative savings by reducing unnecessary care, shifting care to appropriate settings, and curbing increases in unit prices for health care products and services that are not tied to quality.*

The overarching premise for this Plan is a belief that "Advanced Primary Care" — (APC) defined as an augmented patient-centered medical home (PCMH) that provides patients with timely, well-organized and integrated care, and enhanced access to teams of providers — is the foundation for a high performing health system.

To that end, the State aims to achieve three core objectives within five years, namely:

- 80 percent of the population cared for under a value-based financial arrangement
- 80 percent of the population receiving care within an APC setting, with a systematic focus on prevention and coordinated behavioral healthcare
- full transparency over the cost and quality of care at every step of the health care value chain, enabling informed choices by consumers and purchasers

Medical homes have been shown to substantially improve access to needed care, receipt of routine preventive screenings, and management of chronic conditions, and to reduce or eliminate racial and ethnic disparities. Findings in NYS and nationally suggest that a health care system with a PCMH at its heart will achieve the Triple Aim. To that end, New York State is proposing a far reaching set of initiatives that are intended to support and create a more rational, patient-centered care system that is able to provide care that promotes health and well-being for all.

This document articulates and describes New York State's broad strategy for achieving the Triple Aim, which includes five "pillars" (focusing on improving access, care management, increasing transparency, implementing value-based insurance design and community health) and three enablers (investments in the state's health care workforce, in health information technologies and in systems to measure and report on quality, patient satisfaction and cost-effectiveness). These are the state's overarching priorities, which have formed the basis for health reform efforts by the State over the past decade, and will continue to do so, over the next. The following are significant initiatives that the SHIP will build on, incorporate and evolve as part of an overarching vision for health in NYS:

1. New York's Medicaid Redesign Team (MRT) and implementation of its far-reaching recommendations, including a series of delivery system/ payment system innovations such as Health Homes, Managed Long Term Care, a Fully-Integrated Duals Advantage plan;
2. the design and successful implementation of our new health insurance marketplace, The New York State of Health;
3. the commitment by the Office of Health Insurance Programs (OHIP) to improving the quality of primary care services available to Medicaid enrollees, by providing augmented payments to providers recognized by the National Commission on Quality Assurance (NCQA) as PCMHs.
4. the program elements and proposed investments contained in New York's pending request to CMS for a Medicaid Waiver;
5. the State's commitment to promote health at the community level through New York's Prevention Agenda, community schools and the Community Opportunity and Reinvestment initiative;
6. the state's commitment to implement electronic health records and put into place a statewide interoperable health information exchange and All-Payer Database (APD); and
7. the State's commitment to promote and implement value based insurance.

The state's proposed intervention – centered on statewide implementation of an Advanced Primary Care (APC) model, – seeks to align and leverage multiple ongoing initiatives (as noted above). All initiatives seek to create seamless integrated care systems that rely on evolving health information technologies and an emerging primary care workforce, and that aim to promote population health and improve well-being for all New Yorkers. This document describes how we plan to implement that model statewide, over the next five years, using multiple policy levers. A number of agencies within the state government together with the advice and input of external stakeholders will work to achieve this vision:

- The Department of Health (DOH) will provide leadership and discrete support for practice transformation, enhancements to the state's health information technology, and a focused workforce development strategy; and it will provide ongoing oversight and management of the Medicaid program and the State Health Insurance marketplace (The New York State of Health);
- The Department of Financial Services (DFS) will encourage payers to support this new care model, and this Plan, through their regulatory oversight of commercial insurers in New York State;
- The Department of Civil Service (DCS) will support and participate in the implementation of this Plan through their oversight and administration of the State Health Insurance Program for the 1.2 million State and municipal employees; and
- The State Offices of Mental Health and Substance Abuse will participate in the design and implementation of the Plan, to assure that behavioral health and addiction services are well-integrated into the APC model.

The State is prepared to use a number of regulatory levers to achieve these transformation objectives, such as:

- Gaining consensus on standard reporting requirements for payers and providers
- Encouraging payer contributions to primary care to support practice transformation and care coordination to realize improved health and health system savings
- Providing payers with incentives to achieve penetration of value-based payment models and benefit design, as part of the rate-review approval process.

While the broad strategy is well understood and broadly supported by payers, providers, purchasers and consumer groups, the implementation of the Plan requires further definition. To that end, we have included in our implementation plan a detailed design and implementation planning phase, during which we will work closely with stakeholders to define and refine the changes that will be required; and at the same time reviewing existing policies, regulations, and laws to determine whether there are components that could enable and/or present a challenge to the Plan.

Within five years, we anticipate that our investments in this clinical innovation will translate to improved health, measurably lower prevalence of illness and injury, reduced health insurance premium rates, and a more sustainable growth rate in healthcare spending, approximately 2 percentage points below historical

trends[1]. Our goal is to bring the growth of health care spending more closely in line with the growth of our economy—in other words, living within our means so that we can invest a greater share of our productivity gains in education, housing, and other priorities.

We believe that implementing the health system transformation outlined in this Plan is imperative not only to achieve the Triple Aim, but also to improve the competitiveness of businesses operating in New York State and ensure continued, strong economic growth in the years ahead.

OUR PAST EXPERIENCES AND CURRENT INITIATIVES POSITION US TO SUCCEED; OUR CHALLENGES MEAN THAT WE CAN WAIT NO LONGER

Our starting point as a State is defined by both strengths and challenges.

First, the State has strong momentum for shifting to a care delivery and payment model that prioritizes the continuous improvement of the patient experience, the achievement of relevant health care and population health outcomes, and improvements to the efficiency of the health care system.

- 25 percent of New York's primary care providers have achieved recognition by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes;
- As of March 2013, 43 percent of Medicaid managed care members were assigned to a PCMH-recognized provider.
- 95 percent of the state's commercial payers are testing value-based payment methods, including - but by no means limited to - involvement in a variety of medical home pilots and demonstrations across the state;
- New York's Medicaid Redesign Team (MRT) agenda, has defined a path to integrated care for our Medicaid program, including the most vulnerable populations.[2]
- New York's significant participation in programs sponsored by the CMS Center for Medicare and Medicaid Innovation (CMMI), involves more than 150 sites across the State.

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[1] Health care spending per capita in New York State grew at a compound annual rate of 5.5% from 1999-2009, while gross state product per capita grew at a compound annual rate of 3.6%. Source for State health expenditures, Center for Medicare & Medicaid Services (CMS), www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence. Gross State Product Data: U.S. Bureau of Economic Analysis

[2] http://www.health.ny.gov/health_care/medicaid/redesign.

Second, the State has a strong foundation for innovation in our bold health information technology (HIT) agenda, which will integrate data across payers and provide the transparency necessary to improve patient care.

Third, the State has an ambitious and well-defined Prevention Agenda that sets the course for a new level of achievement in public health and prevention.[3]

Finally, the State and its health care stakeholders have a proud tradition of working together to expand access to coverage and services while striving to contain health care cost growth. While NY's spending per capita is 22 percent higher than the U.S. average New York ranks 29th in our health care share of gross State product and 32nd in our spending growth rate.[4]

These strengths will be pivotal in addressing our significant challenges:

- Our most critical challenge is cost—US health care costs are among the highest in the world, and NYS's health care spending per capita is 22 percent higher than the US average.
- Despite high expenditures, our quality of care by most measures is close to the national average, while the prevalence of preventable chronic conditions such as diabetes is rising quickly in New York State, as it is nationwide.
- We rank 50th among states for avoidable hospital use and 40th for ambulatory care-sensitive admissions.

Suboptimal quality means less healthy, less productive New Yorkers, and out-of-control costs hinder economic development for the State. These challenges underscore the urgency in mobilizing this Plan for change.

SHORTCOMINGS OF THE CURRENT SYSTEM

Our current health system fails to deliver the Triple Aim for several reasons:

- Health care providers and services, particularly primary care providers, are not evenly distributed throughout the State and distribution does not necessarily follow need or demand.
- Consumers and their families are largely left on their own to navigate a fragmented system of providers.
- Consumers and their families make health care decisions with little information, or sometimes are not actively involved in decisions made for them.

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3 http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm.

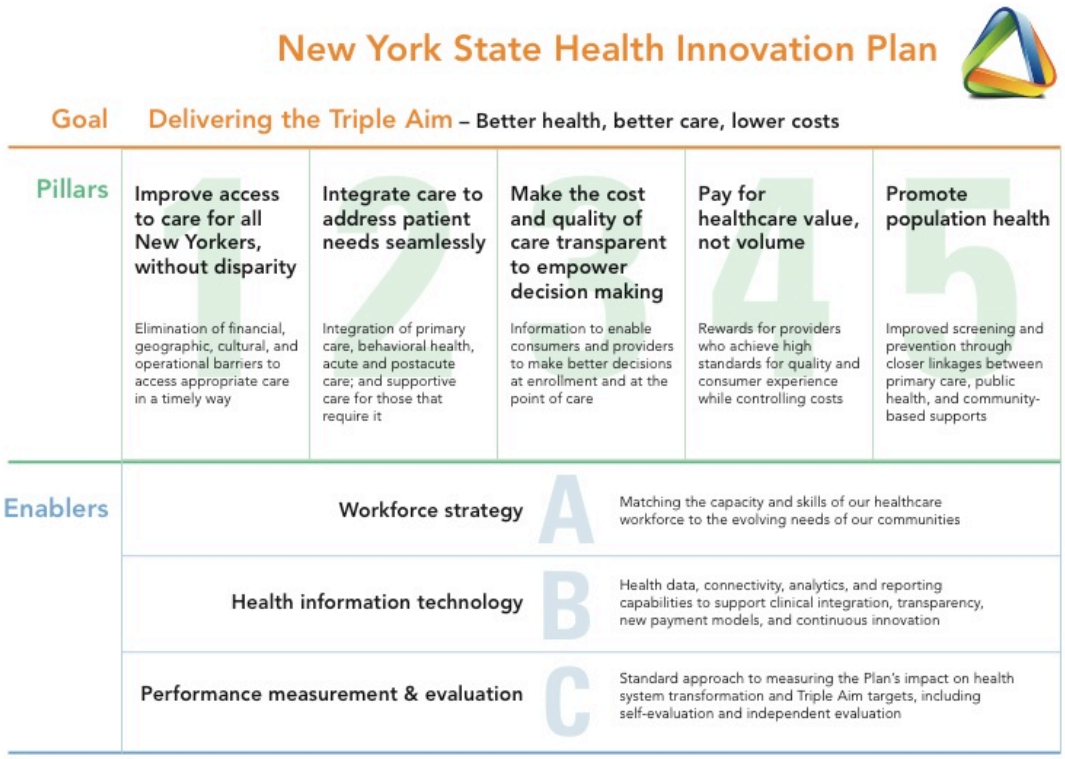
4 Ibid.

- Providers are rewarded for delivering more care, supports or services, whether that care is needed or not.
- Providers who deliver high-quality care, supports or services see no financial benefit to doing so and may in fact be financially disadvantaged for doing so.
- Health care is delivered separate from rather than in concert with population health improvement and local health planning.

OUR PLAN'S FOUNDATION: FIVE STRATEGIC PILLARS AND THREE ENABLERS OF SYSTEM TRANSFORMATION

New York State's Plan to achieve the Triple Aim of improved health, better health care, and lower costs is grounded in our commitment to five strategic pillars

1. **Improving access to care for all New Yorkers, without disparity**
2. **Integrating care to meet consumer needs seamlessly**
3. **Making health care cost and quality transparent to enhance consumer decision making**
4. **Paying for value, not volume**
5. **Promoting population health by strengthening capacity as well as promoting linkages between primary care, community resources, and policies for health improvement**



The design of these pillars builds on the foundation set by the MRT and the Prevention Agenda, the blueprint for how the State will deliver the Triple Aim.

1. Improve access to care for all New Yorkers, without disparity

State goal for Pillar #1	■ Reduce by 50 percent the proportion of adults without a usual source of care. ■ Reduce the size of our uninsured population by 1 million New Yorkers. ■ Substantially reduce waiting times for care.

The first critical step is to ensure that New Yorkers have access, without disparity, to quality health care. The State has performed strongly in this area, with an uninsured population below the national average and relatively high per capita physician ratios. However, we aspire to do much better so that all New Yorkers have timely access to quality care, regardless of their circumstances – where they live, their eligibility for insurance, and/or their cultural or socioeconomic background. The SHIP will strive to assure appropriate access to quality care for

all New Yorkers including racial and ethnic minorities, people with limited English proficiency, immigrants, LGBT individuals and people with disabilities. Our strategy to achieve this has three components:

- Ensure that providers who serve vulnerable populations, including safety net providers who are essential to these populations, have the competencies and capacity to meet demand in a high-quality, timely way. Efforts like the Delivery System Reform Incentive Payment (DSRIP) Program that support safety net providers will be critical in this domain.
- For those eligible for coverage, increase the uptake and adoption of health insurance. A groundbreaking step toward achieving widespread coverage is the New York State of Health, our health exchange marketplace, which was established under the Affordable Care Act through an Executive Order issued by Governor Cuomo in April, 2012. It is here that New Yorkers, including the nearly 2.7 million New Yorkers under age 65 (12 percent of the State's population) who do not have coverage, can shop, compare plans, and enroll in a plan that meets their needs.

  We will continue to work to promote competitive pricing, high quality plans, and high levels of adoption via the exchange, and in parallel, ensure that other health insurance options such as Medicaid and CHIP are successfully reaching their target consumers.
- Grow primary care capacity to meet demand across the State, not just in major metropolitan areas, and to provide quality, culturally-appropriate care to everyone. To achieve this goal, we will continue to refine and expand programs aimed at balancing workforce supply and demand across the full spectrum of clinical capabilities.

2. Integrate care to meet consumer needs seamlessly

State goal for Pillar #2	Ensure that 80 percent of the population receives health care services through an integrated care-delivery model.

The Plan aims to cover as many New Yorkers as possible in an integrated care delivery model within five years. Specifically, we will work to ensure all New Yorkers have access to a new care model, the Advanced Primary Care (APC), which builds on the principles embodied by the NCQA-certified medical home.

As is shown below, the APC model is based on three progressively advanced levels of integrated care: Pre-APC, which includes most primary care practices in New York; Standard APC, a practice which meets and exceeds NCQA's current standards for PCMH recognition; and Enhanced APC, practices in which behavioral health care services are integrated into the primary care setting, and the practice participates actively in initiatives focused on improving the health of the broader community.

The levels of APC capability reflect a practice's capabilities and ability to better manage the health of its patient population. These models will need to be coupled with innovative, tiered payments that cover the incremental costs of registries, care coordination and care management, a variety of gain-sharing incentives for better managing care and costs, and up-front funding to help support technical assistance for practice transformation during the transitions between per-APC and Standard APC, and from Standard to Enhanced APC.

APC Stages of Transformation

Tier	Pre-APC	► Standard APC	► Premium APC
Description	• Largely reactive approach to patient encounters of care	• Capabilities in place to more proactively manage a population of patients	• Processes in place to clinically integrate primary, behavioral, acute, post-acute care[1]
Capabilities required to enter tier	• Limited pre-requisites • Willingness to exchange targeted clinical data	• Certified EHR • Full medical home capabilities, aligned with NCQA Level 1-3, or equivalent	• Certified EHR, Meaningful Use Stage 1-3[3], HIE interoperability • Enhanced capabilities, aligned with expanded NCQA Level 3[2], or equivalent
Validation	None	• Required to maintain care coordination fees >12 months • To couple with practice transformation support	
Care coordination skills	• Limited or none	• Care planning for 5-15% highest-risk patients • Track and follow up on ADT, other scalable data streams • Facilitate referrals to high-value providers	• Plus, functional care agreements in medical neighborhood • Plus, community-facing care coordination
Payment model mix	• FFS + P4P • Potential EHR support	• Shared savings or capitation • Care coordination fees • Transformation support	• Shared savings or capitation
Metrics and reporting	• Standard statewide scorecard of core measures • Consolidated reporting across payers, leveraging APD, portal		

1 Vision, LTC, home aids, rehabilitative & daycare are excluded from all advanced primary care models
2 Establishes additional must-pass NCQA requirements that are not already mandatory in existing NCQA
3 Once available

The APC model is designed to leverage the strengths of New York State's emerging NCQA-certified medical homes while laying out a graduated path for all practices to advance toward integrated care. For example, for providers involved in programs like the Medicaid PCMH Incentive Program, the APC model represents an evolution toward stronger integrated care and capabilities for care management.

The APC model will go beyond new structures and capabilities to specify and measure processes and outcomes associated with more integrated care, including prevention, effective management of chronic disease, integration with behavioral health, and coordination among the full range of providers working together to meet consumer needs. We believe this is essential in moving away from a reactive health care system that patients largely have to navigate on their own, to a truly proactive system, in which patients are helped to actively manage and improve their health.

Over the coming five years, we will work to actively promote participation in the APC by all major payers in the State - Medicaid, NY-SHIP, Medicare, and commercial payers, including self-insured arrangements with purchasers. The APC will provide care that is well integrated with services for special populations through unique care models such as health homes and the Fully Integrated Duals Advantage (FIDA) program.

Where there are adjacencies between the APC and other models serving special populations through these unique care models (Health Homes, the FIDA demonstration, and the behavioral health carve-in.[5]), the APC model is designed to reinforce the value of the primary care provider in supporting those populations.

At a programmatic level, the Plan will be harmonized with the pending MRT 1115 waiver[6] and its related projects, such as the Delivery System Reform Incentive Payment (DSRIP) Program.

Processes to confirm eligibility, enroll providers into the program (for instance, on a payer by payer basis), measure progress, and align activities and outcomes with payment (see Pillar #4) will be developed in early 2014. In order to minimize the administrative burden, the eligibility process will be grounded in preexisting medical home recognition approaches such as NCQA or CPCi.

3. Make health care cost and quality transparent to empower consumer decision making

State goal for Pillar #3	■ Achieve 80 percent PCP participation in the All-Payer Database and/or Health Information Exchange. ■ Engage 20 percent of consumers in active use of their patient portal.

The Plan will generate an unprecedented level of health data transparency, which will empower consumers, providers, and payers to make increasingly informed decisions about the quality and costs of the care they seek and provide. Specifically, it is anticipated that within three-to-five years there will be statewide transparency of core quality, utilization and cost metrics at a facility and practice level, including a consumer-targeted website to provide this information in a user-friendly format to enable consumer action and shared decision-making.

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5 For more detail on these programs, see Appendix, "Existing Programs and Waivers."

6 http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf.

In addition, every New Yorker will have secure electronic access to his or her personal health records that include current health information from all providers he or she has accessed throughout the system. These records will be transferable to payers and providers and supported by interactive tools to help consumers optimize their healthcare decisions. These efforts will require essential technological infrastructure as well as strategies that make it both easy and rewarding for consumers to actively engage in health data and use it to make informed decisions about the care they access while ensuring the necessary privacy protections.

4. Pay for value, not volume

State goal for Pillar #4	■ Ensure that 80 percent of covered lives are contracted under value-based payment models.

The Plan will promote incorporation of meaningful, value-based payment arrangements across the State's payers and insurers, with the goal of rewarding providers who help patients stay healthy and achieve quality health care outcomes at an efficient cost.

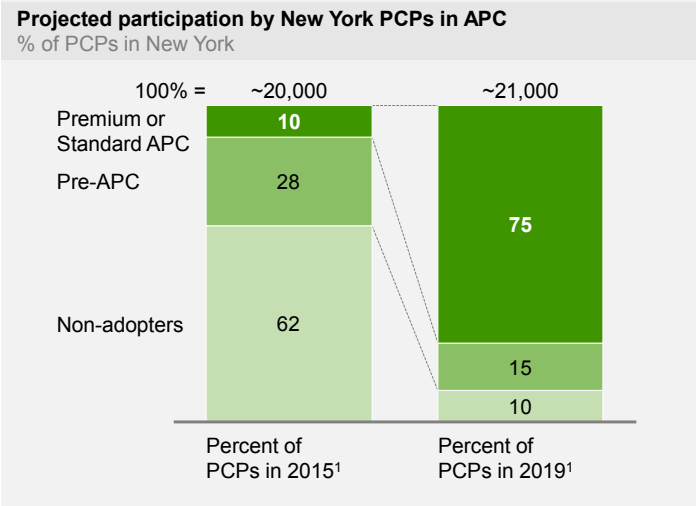
In order to promote innovation, the Plan's goal is not to standardize specific payment arrangements or value-based models. Instead, a spectrum of 'value-based payment models' has been defined. Within this spectrum, payers and insurers can determine the detailed design and distribution of models they will develop in order to move towards the target of 80 percent of covered lives in value-based arrangements.

As a starting point for discussion, the spectrum of payment models for eligible APC practices could reflect a practice's current status: pre-APC practices may be best suited to "pay-for-performance" arrangements, whereas more advanced, standard and enhanced APC practices may be better suited to participate in gain-sharing or risk-sharing arrangements.

The financial return to practices should increase as they advance their APC status – reflecting the additional value they create in helping their patients achieve strong health outcomes in a cost-effective way. Based on this framing of the payment spectrum and current estimates of NCQA recognition and EHR penetration, we project that nearly 40 percent of New York PCPs could be ready for some degree of APC participation in 2015 and that by 2019 the number will rise to 90 percent.

By 2019, 90% of New York PCPs will be on the glidepath of APC, with the vast majority at the Standard or Premium level

PRELIMINARY



1 PCP includes internal practice, general practice, family medicine, OB/GYN, and pediatrics, 2 Excludes dual eligibles
SOURCE: Kaiser Family Foundation; New York Department of Health; SK&A Data September 2013; CMS

The detailed design and distribution of payment models will be the responsibility of payers, working with providers. The Department of Financial Services (DFS) health insurance premium Rate-Review process will be refined to encourage a timely transition to at least 80 percent penetration of value-based payment models. The process will also recognize that achieving this goal may necessitate initial investments by insurers.

The State will also encourage broad use of value-based insurance design (VBID) by helping to create transparency about best practices in VBID and encouraging broad based adoption of such practices across payers (see Section 4, below). It is anticipated that Medicaid and NY-SHIP could take a leading role in this endeavor, implementing high-impact VBID into their plans, and that DFS could encourage increased use of VBID through its policy form approval process.

Finally, it should be noted that value-based payments in the APC model will complement value-based payment approaches focused on targeted populations. These include a number of Medicaid approaches such as the Behavioral Health carve-in to establish risk-bearing Special Needs Plans; Integrated Delivery Systems that specialize in managed care for patients with significant behavioral health needs; and the FIDA demonstration project, which enrolls Long Term Care (LTC)-intensive dually eligible members into fully integrated managed care products.

5. Promote Population Health

State goal for Pillar #5	■ Connect 90 percent of PCPs to community-based organizations working to support population health through high-quality registries of community health-focused organizations. ■ Promote regional health planning

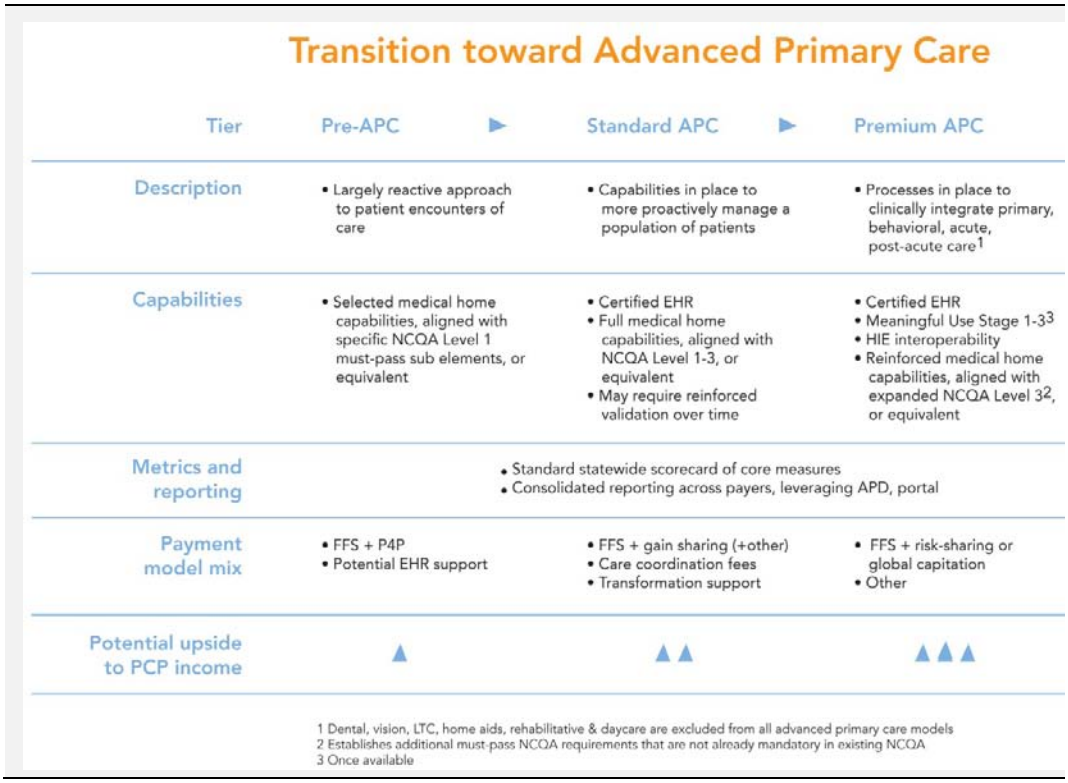
We realize that many of the determinants of health and health care outcomes are influenced, if not determined, by factors outside the health care delivery system. The Plan uses the State Health Department's Prevention Agenda 2013–2017 as a guide for building healthy communities and citizens and targets specific opportunities to enact and meet the goals and objectives of the Agenda. Specifically, the Plan will work to strengthen links between primary care, hospitals, long-term care providers, local health departments, and a variety of community stakeholders to ensure a truly integrated approach to identifying and addressing local health challenges. These linkages will focus on

a. the prevention of chronic illnesses whose rise and prevalence are most threatening to the health of New York communities, including obesity, diabetes, heart disease, hypertension, smoking, and colorectal cancer;
b. the promotion of healthy women, infants, and children;
c. the provision of effective mental health and substance use prevention and treatment services; and
d. the prevention of HIV, sexually transmitted diseases, and vaccine-preventable diseases.

The Prevention Agenda also prioritizes the promotion of health and safe environments and addresses local health disparities. Linkages will be created through regional resource centers involving county and city health departments and regional health planning organizations, such as Regional Health Improvement Collaboratives (RHICs), with opportunities for APC practices to take on a more proactive role in these community-based partnerships, e.g. by participating in regional health planning efforts.

APC practices are well positioned to help RHICs, whose responsibilities are to help community stakeholders identify opportunities to improve health care quality and value, facilitate planning and implement strategies that address those opportunities. In addition, community resource registries will be used to enable primary care practices to create effective linkages with community- based organizations and partnerships focused on aspects of prevention or health improvement (for instance, chronic disease self-management programs).

The types of organizations may vary according to regional needs; a simultaneous State and local priority should be to ensure there are sufficient and thriving community resources available. Measuring these linkages and the resulting population health outcomes will form a core part of the Plan's evaluation focus at the system level, and will be reflected in the practice-level APC recognition processes and payment models.[7]



Transition toward Advanced Primary Care

Tier	Pre-APC ►	Standard APC ►	Premium APC
Description	• Largely reactive approach to patient encounters of care	• Capabilities in place to more proactively manage a population of patients	• Processes in place to clinically integrate primary, behavioral, acute, post-acute care[1]
Capabilities	• Selected medical home capabilities, aligned with specific NCQA Level 1 must-pass sub elements, or equivalent	• Certified EHR • Full medical home capabilities, aligned with NCQA Level 1-3, or equivalent • May require reinforced validation over time	• Certified EHR • Meaningful Use Stage 1-3[3] • HIE interoperability • Reinforced medical home capabilities, aligned with expanded NCQA Level 3[2], or equivalent
Metrics and reporting	• Standard statewide scorecard of core measures • Consolidated reporting across payers, leveraging APD, portal		
Payment model mix	• FFS + P4P • Potential EHR support	• FFS + gain sharing (+other) • Care coordination fees • Transformation support	• FFS + risk-sharing or global capitation • Other
Potential upside to PCP income	▲	▲▲	▲▲▲

1 Dental, vision, LTC, home aids, rehabilitative & daycare are excluded from all advanced primary care models
2 Establishes additional must-pass NCQA requirements that are not already mandatory in existing NCQA
3 Once available

THREE ENABLERS ARE FOUNDATIONAL TO ALL STRATEGIES

A. Health care workforce strategy

A targeted health care workforce strategy, building on those of the MRT, will be deployed to assist in balancing the supply and demand of specific skills that will be required under the new APC model. The strategy has four areas of focus.

First, it is imperative to increase the recruitment and retention of a primary care workforce throughout the State. This includes not only primary care physicians but also health care workers who support the delivery of primary care, specialists who deliver primary care and ambulatory care providers.

[7] http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm.

Second, it is essential to update standards and educational programs for all types of health care workers to reflect the needs of delivering the APC model, particularly training in care coordination, multidisciplinary teamwork, and necessary administrative and business skills. Effective care coordination will integrate care within and beyond the medical neighborhood[8] to interface with relevant community organizations that provide supportive services such as food, housing and other social supports where they are available. It will also enable providers to address the needs of complex and vulnerable populations.

Third, it is critical to identify potential primary care-related workforce flexibility opportunities by putting in place the infrastructure to test and evaluate workforce models of care and their implications for professionals to work closer to the top of their licenses.

Finally, it is important to assure adequate education and training throughout the State and to develop more robust working data, analytics, and planning capacity. Although the focus of the Plan outlined in this document is on strengthening the primary care workforce, the State also intends to ensure appropriate capacity and competencies of the specialist care workforce, including mental health, long-term care, and home care providers.

B. Health information technology

Under the Plan, the State will build on and expand its current development and deployment of health information technology (HIT). This program will implement the aggregation of data through the All-Payer Database (APD) and the exchange of patient level clinical data via the Statewide Health Information Network for New York (SHIN-NY)—the State's evolving, health information exchange architecture. This new architecture will provide the core analytic and reporting capabilities required to understand payer and provider-level outcomes, utilization, and costs, and will have an interoperable interface that offers decision support and transparency tools for payers, providers, and consumers.

In addition, these data platforms and NYS's extensive public health database will be leveraged to provide communities (for example, the emerging Regional Health Improvement Collaboratives) with valuable population-level health data so that public health efforts are aligned with care delivery in the health system. Some of these tools will be State-developed, while others will be developed by local users and the private sector. Interoperability standards across providers will ensure that

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[8] The medical neighborhood refers to the collection of teams, practices, and community resources that provide health services, or services in support of health, to patients. From a primary care point-of-view, this includes other specialist care and hospital care that a practice's patients utilize, as well as community and social service organizations and public agencies.

HIT investments by stakeholders will enhance the ability to produce and use "big data" to improve care, from the patient to the system level.

C. Performance Improvement: Quality Measurement and Evaluation

The State, through collaboration with stakeholders, will develop a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivery within the State Health Innovation Plan. A core set of industry-standard metrics will serve as a common basis for measuring progress and impact of the Plan as well as that of the new APC model. Existing metrics from the MRT, health plans, and hospitals will provide the basis for this approach and will be augmented and triangulated with selected metrics from the Prevention Agenda, the Collaborative Care model, multipayer Advanced Primary Care demonstrations such as the Comprehensive Primary Care initiative (CPCi), and the Multipayer Advanced Primary Care Practice Demonstration (MAPCP) and other industry standards.

This Plan contains a rigorous first draft of a proposed 'standard scorecard.' 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 NY-SHIP 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.

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.

THROUGH A FIVE-YEAR TRANSFORMATION, WE WILL USHER IN A NEW ERA OF HEALTH CARE VALUE, AND A HEALTHIER NEW YORK

The transformation roadmap reflects our bold commitment to moving the needle on the Triple Aim in the next five years. It also reflects our commitment to making this process a truly collaborative journey, thus allowing time for sufficient and

meaningful engagement with all the partners who work together to deliver health care in New York.

The transformation journey will have four key phases:

- **Finalize the detailed Plan design (January–September 2014)**. During this phase, we will establish the State-level delivery and governance mechanisms to drive the Plan's finalization and implementation and set up the key stakeholder working groups required to help us navigate the journey ahead. A key part of this phase will be working through the detailed design of the operating model – including how practice transformation will be supported, how care coordination will be enabled, and precisely how the Rate Review process will operate. In addition, work will be undertaken to ensure that the necessary funding is in place to support Plan delivery and, in particular, delivery of the HIT enablers such as the APD and EHR adoption. We will begin to define common performance metrics, align on a common dashboard to measure the Plan's progress, and develop a statewide APC performance tool for providers and payers.
- **Prepare for implementation (October 2014–April 2015)**. During this phase, we will lay the groundwork for the new operating model, including building regional support capabilities where required, publicizing APC eligibility standards, and building provider access points and APD-based analytic capabilities. We will advance any regulation or legislation required to support the capture and flow of data required for maximum effectiveness of the APD and the SHIN-NY. The rollout of the HIT program will progress at a steady pace.
- **"Go live." Supporting transformation (April 2015–April 2016)**. In this phase APC recognition will begin. DFS will start conducting rate reviews using a newly enhanced process that recognizes payer innovations and investments in APC models. Health data transparency and reporting will begin to reach scale, and the State will work to support regional governance entities as they operationalize practice transformation and care coordination efforts and supports. In addition, the State will encourage the participation of purchasers in self-insured arrangements and support the implementation of Medicaid and NY SHIP approaches to APC.
- **Continuous improvement and refinement (April 2016 onward)**. Refinement of the care and payment model(s) will continue to evolve based on experience. The connection of APCs to population health in the community will continue, and ongoing refinement of common measures to ensure relevance to all stakeholders will take place. The State will work with stakeholders to ensure that information and reporting are optimized and to identify and resolve challenges as they arise. Evaluations and feedback from

all stakeholders will guide appropriate evolution of standards and best practices

THE STATE WILL LEAD EXECUTION OF THE PLAN IN CLOSE PARTNERSHIP WITH STAKEHOLDERS

In order to achieve this ambitious end-state, the leadership role of the State will be important. Our leadership team reflects cross-agency collaboration across our departments of Health, Financial Services, and Civil Service (in its role as the health care purchasing arm of the State's Council on Employee Health Insurance), as well as other health-related State agencies. That momentum already exists among payers and providers. To move in the direction outlined by the State Health Innovation Plan, New York will focus on removing barriers, enabling standardization where required, and encouraging rapid adoption of the targeted care delivery and payment models. Specifically, the State will support execution of the Plan in three ways:

- **Convening and facilitating alignment**: The State—through a cross-agency collaboration of DOH, DFS, DCS, and DOB, and including providers and payers—will facilitate alignment in four key ways.
  - *First*, it will work within the NCQA patient-centered medical home recognition process to reflect the three proposed APC levels, and will consider adapting the process if practicable and if needed, thereby building on the existing NCQA framework to minimize the administrative burden on practices and payers. Transitional recognition for both current NCQA and other industry standards (for example, CPCi) will be maintained for a defined period. The State will be open to other options for recognition of APC eligibility as needed.
  - *Second*, it will facilitate the collaborative creation of, and then actively promote the adoption of, industry-standard metrics by publishing a core list of APC metrics, using these metrics in its Medicaid and NY-SHIP contracts related to APC, and, as mentioned above, supporting APC metrics via state-enabled HIT. The core list of metrics will represent a beginning set of metrics, with room for regionally-tailored metrics to supplement the set.
  - *Third,* the State will act as a facilitator by encouraging the formation of regional support models to assist practice transformation and convene shared resources for care coordination. In doing this, the State will build on existing collaborative arrangements that have already gained significant traction (for example, in the Finger Lakes and Adirondacks) while also seeking to leverage other regional structures (including county health

departments and potentially, the 11 newly proposed Regional Health Improvement Collaboratives).

  - *Finally*, the State will facilitate a broader stakeholder engagement process to ensure that multiple perspectives are reflected in the final design and implementation.

- **Delivering**: The State will play the lead role in delivering three key enablers of the Plan pillars.
  - *First,* it will continue building the backbone of the HIT system to enable required flows of data between payers, providers, purchasers and consumers (through large-scale efforts such as the APD and the SHIN-NY).
  - *Second,* it will define the beginning, core set of metrics for quality, utilization, and cost performance.
  - *Third,* it will support the analytic engine to collect and report on these metrics, delivering core information required to support the APC model and associated payment models to all system participants, including providers and payers.
- **Incentivizing**: The State will explore using the Rate Review process as a core mechanism to encourage payer innovations and investments in the implementation of APC models developed in collaboration with participating providers. The process may also be used to align payer progress and policies with the Plan, including moving toward the adoption of APC models and associated value-based payment.

- The State intends to work closely with payers and providers in finalizing the design of this process, recognizing that insurers may need to make initial investments in prepared provider practices in order to innovate. The intention is to provide payers as much flexibility as possible to innovate and autonomously manage their portfolio while ensuring that the health system as a whole moves away from fee-for-service payment and toward a value-based payment model over time. To achieve this, it is anticipated that, as part of the Rate Review process, payers will have an opportunity to report on how their provider portfolio is distributed against value-based payment models, including the APC recognition levels and to describe the penetration over time of value-based payment models and VBID.

OUR GOVERNANCE MODEL WILL ENSURE CROSS-AGENCY COORDINATION AND PUBLIC-PRIVATE COLLABORATION

Our State Health Innovation Plan is ambitious. Effective delivery over the next five years, and in particular during the critical start-up period over the next two

years, will require extensive collaboration and coordination both among the agencies of New York State and across the regional and statewide stakeholders that constitute New York's health care landscape. As a State we have demonstrated large-scale transformations multiple times in the past: we know how challenging it is, but we also know what it takes. Importantly, we know that a key enabler of success is a clearly-defined governance model, coupled with a high-powered, high capability program management office that ensures cross-agency coordination, private-sector collaboration, and accountability to the Plan.

Our approach to governance reflects three key beliefs regarding what it will take for New York to succeed:

- **Consistent coordination among State agencies with a stake in Health.** The health of every New Yorker and the long-term solvency of our State's economy are at stake; hence, the Department of Health (DOH), Department of Civil Service (DCS), Department of Financial Services (DFS), and the Division of Budget (DOB) must lead the way together, each marshaling its expertise and resources to meet their shared mandate, and coordinating with one another to generate the most effective implementation the State can achieve. These four agencies will jointly own the delivery of Plan outcomes, with the Commissioner of the Department of Health taking the lead.
  - The leadership team will include other key health-related agencies, including the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), as well as agencies whose programs and services impact health, such as Housing and Children and Family Services. Governor-led initiatives such as Community Schools will also be included. The 38 individual initiatives that jointly comprise the Plan are allocated to agency and department level ownership. Finally a high visibility, high capability Program Delivery Office will be established to coordinate across agencies and ensure delivery against our ambitious goals.
- **Strong public-private collaboration.** Our care delivery system comprises a complex array of stakeholders; all need to be a part of the solution. There will be a stakeholder steering committee charged with aligning on overarching design and implementation issues.
  - We will establish a health delivery system workgroup inclusive of both providers and payers with the mandate and capacity to agree on core principles of payment models that support and encourage the delivery transformation this plan seeks to achieve. This group will also be charged with developing recommendations to create a standardized set of performance metrics and will be asked to leverage shared HIT platforms like the APD.
  - Additional Groups will be convened to ensure that this effort is truly collaborative and will include representatives familiar with consumers,

community and regional efforts, employers, public health, workforce and other health care stakeholders. Our Program Delivery Office will ensure tight integration between Steering Groups and internal, cross-agency working teams.

- **Regional oversight of implementation.** The richness of capabilities, depth of contextual knowledge, and deep commitment of our regional partners mean that progress and success should be driven locally. We wish to enable regional entities to lead Plan implementation in ways that make most sense.
- Regional entities will be best equipped to set local priorities, convene local stakeholders, and support mechanisms of regional implementation, such as regional contracting to provide practice transformation.
- In the coming months, we will work together with our Steering Groups to define how to optimally integrate entities like the proposed Regional Health Improvement Collaboratives and local Prevention Agenda partnerships, local county health departments, and a strong roster of preexisting convening organizations across New York communities. Once this has been determined, we will work quickly to support and enable regional entities to take stock of the resource and capability needs that must be addressed to jointly deliver on the full aspirations of our Plan.

* * *

Achieving the Triple Aim is not a choice, it is an imperative. Our State Health Innovation Plan is not just an opportunity; it is an obligation that we, collectively across our health care system, have to all New Yorkers.

New Yorkers across the State, of all economic and cultural backgrounds and across the spectrum of health needs, deserve a health care system that delivers high quality, cost-efficient care with only the best outcomes. They deserve health care, supports and services that comprehensively attend to whole person-centered health, from the primary care setting throughout the medical neighborhood and into the community, and that is tightly harmonized with community efforts to support healthy populations.

It is imperative not only to support quality, healthy lives, but also to ensure that New York State continues to grow as a vibrant, strong economy.

I. Introduction

1. State Goals

New York State has a bold, ambitious vision for health care, which is firmly grounded in the Triple Aim. The State Health Innovation Plan (referred to in this report as the Plan) defines the roadmap by which we will achieve this vision. The Plan comprises five strategic pillars and three cross-cutting enablers, which collectively will help us to transform the system from a reactive, volume-based care-delivery system that New York consumers have to navigate largely on their own, to a proactive, prevention-focused, and value-oriented system that is both patient-centered and broadly accessible.

The centerpieces of this transformed health care system is evolution of an advanced primary care (APC) model that builds off of multiple ongoing initiatives, particularly patient centered medical homes (PCMH), but takes the model a step further to promote integration and collaboration sufficient to improve overall health and well-being, and achieve the goals of the Triple Aim.

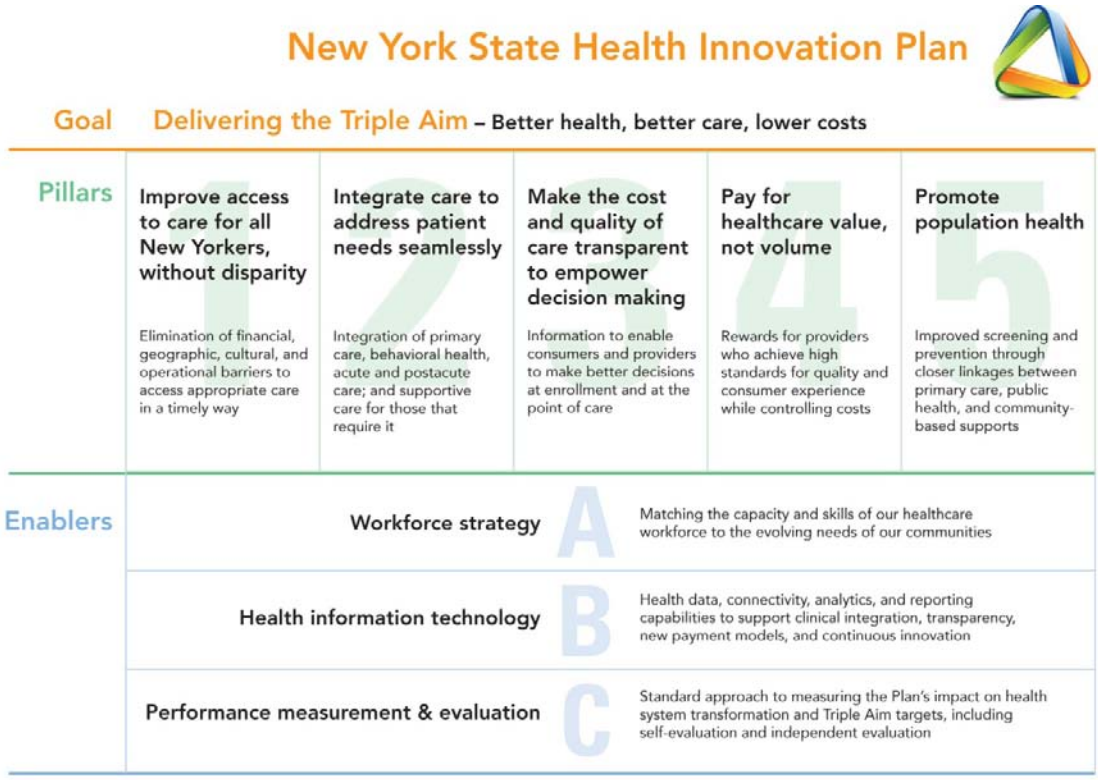
Through supports and incentives, the envisioned APC model will be better connected with the medical neighborhood – defined to include high-value specialty care and hospitals. While the focus of the initiative rests with primary care, this model will succeed only through true integration with medical and surgical specialists who consult and provide specialty care to patients of a Primary Care Provider (PCP). In addition, many specialists have patients for whom they function as a PCP. These physicians and the patients they serve are likely to be key participants in the APC model as it evolves. As the volume of specialty care is "right-sized" in the coming years these physicians may be able to provide incremental primary care and thus meet some of today's unmet demand.

Hospitals play a critical role in the primary care arena as major providers of ambulatory primary care providers through clinics and practices of employed physicians. In addition, for true integration, linkages must be clear and readily accessible between APCs s, acute and ambulatory care providers, emergency departments, school-based health centers and specialty providers. Of particular import are teaching hospitals who work to train physicians and other care providers – training which must emphasize the need for and mechanisms to support fully integrated delivery systems.

The pillars and enablers which provide the framework for the Plan are set out in Exhibit 1 below. In this section we define the specific targets and goals we are

setting for ourselves and by which we will measure our success over the next five years.

EXHIBIT 1: DELIVERING THE TRIPLE AIM



1.1 TRIPLE AIM OBJECTIVES

At the highest level, the State is committed to the Triple Aim, to be achieved in the next five years through the five pillars and associated goals as defined in Exhibit 2. Our first goal, related to Improving Health, is to achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement. Core to achieving this goal will be increasing New Yorkers' access to health care without disparity, focusing on primary prevention at the clinical and community level, and implementing effective linkages between primary care and community-based organizations. Our second goal, related to Improving Care, is to improve patient-centered care as measured by chronic disease management (diabetes and cardiovascular care), improved care transitions and improved CAHPS scores. To achieve this we will adopt a more proactive and integrated approach to primary care, with a specific focus on higher-risk populations and a spotlight on secondary and tertiary prevention. Our third goal is to generate $5 to $10 billion in cumulative savings over 10 years, by reducing unnecessary utilization, shifting care to appropriate

settings and curbing increases in unit prices, which we will seek to enable through increased transparency of cost, utilization, and quality performance as well as through better alignment of incentives with total cost of care performance. We seek to reduce avoidable admissions and readmissions by more than 20 percent of the current rate by 2019.

EXHIBIT 2: EVALUATION DASHBOARD

New York State Healthcare Innovation Plan
Evaluation Dashboard

Acceptable | Unacceptable | In-progress | Tracking indicator only

The Triple Aim	Metrics	Current level	Units	Rank	2015	2016	2017	2018	2019 target, level	2019 target, rank
I. Improve health	Quartile performance on core aspects of public and preventative health	2nd	Quartile		-	-	-	-	1st	12
II. Improve care	Hospital Admissions for Ambulatory Care Sensitive Conditions per 100,000 Beneficiaries	5907*	Admissions per 100,000	n/a	-	-	-	-	4550*	n/a
	30-Day Hospital Readmissions as a Percent of Admissions	21*	Percent	n/a	-	-	-	-	16*	n/a
III. Reduce costs	% cost reduction compared to projected baseline (over 10 years)	0	Percent	n/a	-	-	-	-	2%	n/a
	Cumulative savings compared to projected spend	0	Percent		-	-	-	-		n/a
Strategic pillars	**Metrics**	**Curent level**	**Units**	**Rank**	**#**	**#**	**#**	**#**	**2019 target, level**	**2019 target, rank**
1. Improve access to care across the State	# of uninsured New Yorkers newly covered by health insurance	0	Persons	n/a	-	-	-	-	1M	n/a
	% of adults without a usual source of care	20	Percent	13 of 51	-	-	-	-	10	tbd
	Waiting times for safety-net providers	n/a	Minutes	n/a	-	-	-	-	TBD	n/a
2. Ensure integrated care for all	% New Yorkers in a recognized, integrated care model	n/a	Percent	n/a	-	-	-	-	80	n/a
3. Make healthcare transparent to empower consumers	% consumers using transparency or patient portals to inform decisions	0	Percent	n/a	-	-	-	-	20	n/a
	% PCPs actively engaged with APD and/or HIE	18†	Percent	n/a	-	-	-	-	80	n/a
4. Pay for value, not for volume	% of total healthcare spend linked to value-based plans	n/a	Percent		-	-	-	-	80	n/a
5. Connect healthcare with the community	% PCPs using locally maintained community resource registry	n/a	Percent	n/a	-	-	-	-	100	n/a

* Figures here based on Medicare populations; future measures will aim to be all-payer
† Data only available for all physicians at this time. Figure here based on HIE adoption. The All Payer Database is in development.

1.2 SUPPORTING GOALS AND OBJECTIVES

Supporting our Plan's three main goals is a cascaded series of targets and metrics that will be evaluated throughout the five-year plan-delivery period. These targets and metrics are defined in detail in the "Performance Measurement and Evaluation" section. However, at the highest level, we have selected a subset of these factors to comprise our pillar-level targets, set out in Exhibit 2 above—which also shows where New York State's baseline performance is today—and summarized below.[9] By 2019:

[9] Some of the measures discussed above will require further design of data and technical requirements. This represents ongoing work and is further discussed in the "Performance measurement and evaluation" section.

- **Reduce by 50 percent the proportion of adults without a usual source of care; reduce the size of our uninsured population by 1 million New Yorkers;[10] and substantially reduce waiting times at safety-net providers**: Collectively we aim to achieve these targets by ensuring that the New York Health Exchange attracts high-value, competitively-priced plans that our customers statewide will find appealing and want to adopt. We will also work to ensure public health insurance programs like Medicaid and Children's Health Insurance Plan (CHIP) are reaching their target populations. In addition, the Delivery System Reform Incentive Program (DSRIP) program will help to ensure that providers serving vulnerable populations have the resources and capabilities required to provide timely access to quality care, without disparities.
- **Ensure that 80 percent of the population receives health care, supports, and services through an integrated care delivery model**. We believe this model of care is critical to keeping people healthy and for providing high-quality, high-value care in the right setting. This model includes care delivered under the APC model, as well as through specialized models of care: health homes and care provided under long-term care (LTC) agreements or programs equivalent to the FIDA demonstration models.
- **Achieve 80 percent PCP participation in the All-Payer Database and/or Health Information Exchange; engage 20 percent of consumers in active use of their patient portal**.[11] Data is a key enabler through which our health system's stakeholders—payers, providers, and consumers alike—will be able to make more informed choices that are linked to quality and value. We will achieve these goals by State-led delivery of the All-Payer Database and HIE backbone infrastructure, coupled with incentives, particularly for smaller, independent practices, to encourage broad adoption and usage.
- **Ensure that 80 percent of health care spending is contracted under value-based payment models.** This initiative will define our statewide shift from fee-for-service (FFS) payment. We will achieve this goal by working with payers and providers to agree to a spectrum of promising and innovative value-based payment models, which may be considered for adoption as a component of the Rate Review process to recognize payer and provider efforts to support the Plan.

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[10] Targets are estimated based on "Uninsured New Yorkers After Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area," May 2013 revision.

[11] We anticipate that consumer activity may be measured through counts of online traffic, e.g., unique logins.

- **Connect 90 percent of PCPs to high-quality registries of community health-focused organizations.** We recognize that material improvements in health require changes that go well beyond the medical neighborhood and deep into the community. To ensure that PCPs have the information necessary to link their patients to supportive community organizations, particularly smaller or independent practice providers, we will work with county health departments and regional planning entities to develop and maintain registries of local organizations that provide care, support and education to improve community health and well-being. Through these linkages we aspire to promote overall efficiency and effectiveness, and achieve gains in population health.

  We acknowledge that the goals we have set for ourselves are ambitious, and there is plenty of hard work ahead. We also note that we cannot achieve these goals in isolation—we will be working closely with the many payers, providers, purchasers, associations, interest groups, and consumer and workforce advocates who make important contributions to the health care landscape in New York. We are encouraged by the energy and momentum for change that these groups are already bringing to the journey and look forward to their partnership on the road ahead as we work toward our ambitious goals.

2. State Health Care Environment

While the Plan sets out a vision for the future of health care delivery in New York, it is also firmly grounded in a comprehensive understanding of what health care in the State looks like today. Over recent years, we have built a strong foundation for transformation—through investments in health information technology (HIT), successful pilots of APC models and payment reform, the development of a comprehensive Prevention Agenda, and the Medicaid transformation set out in the pending MRT 1115 waiver. In spite of this, our health system performance still falls short of our expectations for the Triple Aim. Our per-capita costs remain 20 percent higher than the national average, our health outcomes are too often 'average' and the prevalence of chronic conditions including obesity and diabetes continues to impact more than 20 percent of New Yorkers. In addressing these performance challenges, we must acknowledge our unique demographic complexities (our scale, mix of urban and rural populations, and extent of racial, ethnic and socioeconomic diversity) and diverse employer, provider, and commercial purchaser landscape. At the same time, in addressing these challenges we will play to our strengths – including our record of innovation, experience developing a multi-stakeholder MRT, and the purchasing scale that Medicaid and NY-SHIP collectively represent.

This section describes New York State's current health care environment from three important perspectives: our current performance (in terms of public health and health outcomes, efficiency and cost, and patient experience); our population demographics; and our market landscape (in terms of payers and providers).

2.1 OUR DEMOGRAPHICS AND HEALTH CARE MARKET STRUCTURE

2.1.1 Population demographics

New York is the third-most populous state in the United States, after California and Texas, and has a demography that is largely reflective of the national average.

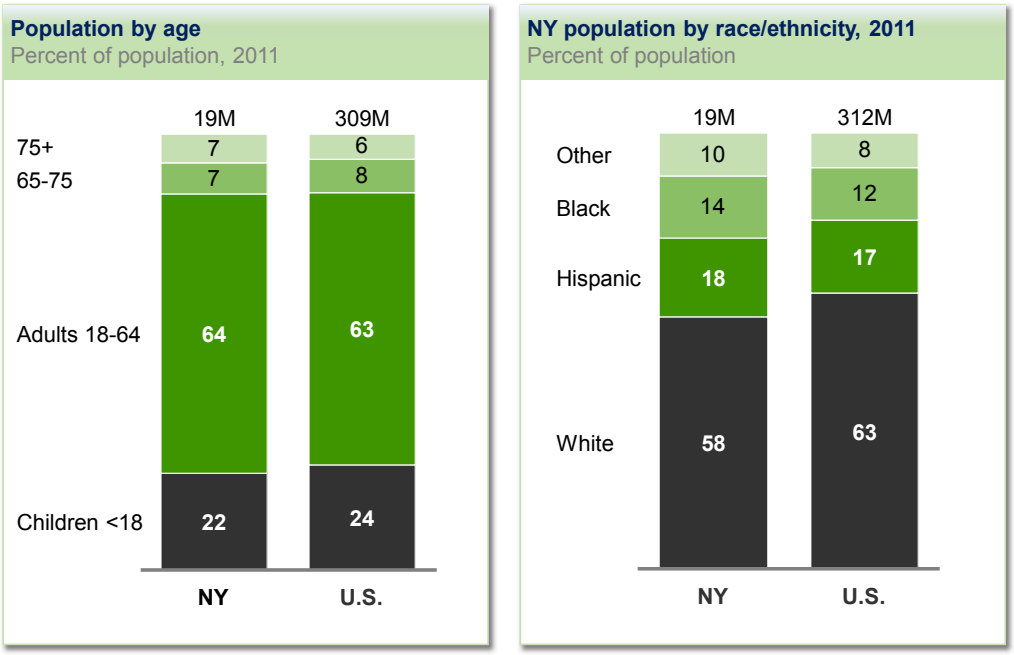
New York's population has a similar age distribution to the national average, but a higher level of ethnic diversity, as described in Exhibit 3. The State's incidence and distribution of poverty also mirrors the U.S. average, as does educational attainment at the high school level. The penetration of advanced education is 4 percent higher than the national average, and the median annual income, at $57,395, is approximately 8 percent higher than the national average.[12] Unemployment is somewhat higher in New York than elsewhere. At the end of

[12] Based on median annual per-capita income from U.S. Bureau of Labor Statistics.

2012, the state's unemployment rate was 8.3 percent compared to the national average of 7.8 percent.[13] In the decade before the 2008 recession, New York's unemployment rate ranged from a high of 6.42 percent to a low of 4.55 percent. Since 2009, however, average unemployment has clustered around the 8 percent mark.[14]

EXHIBIT 3: POPULATION MIX

New York State's age distribution mirrors the national average but its population is more diverse compared to the U.S. as a whole



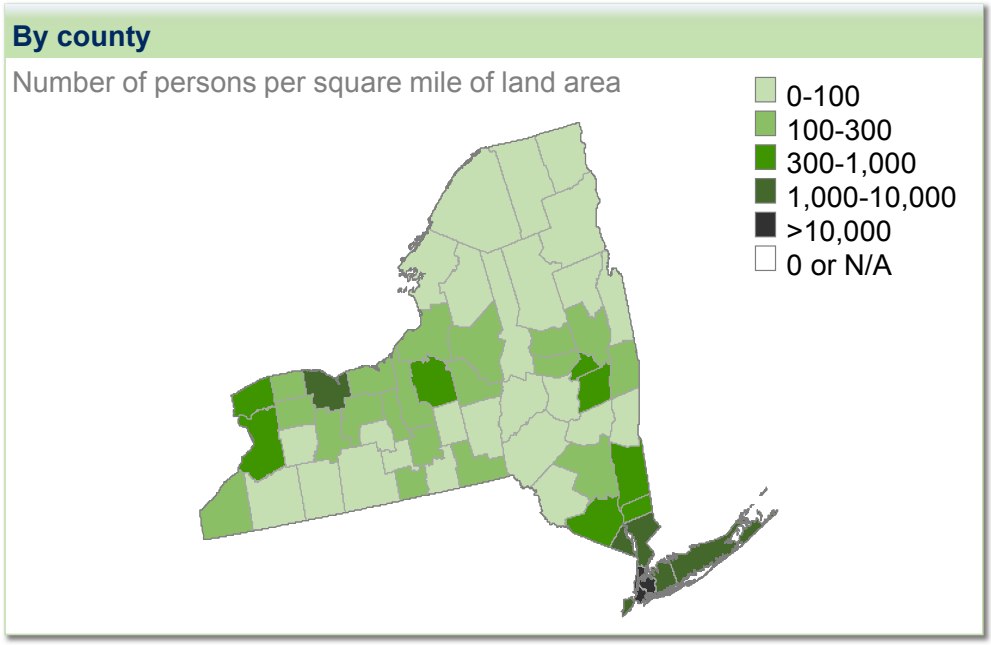
SOURCE: U.S. Census American Community Survey; U.S. Census Current Population Survey

More than 80 percent of New York's residents live in urban areas. Statewide, the average population density is 4.6 times greater than the national average of 89 people per square mile. With a density of 1,000 to 10,000, Greater New York City, Long Island, and Buffalo are the densest areas after New York City's five boroughs. There, the density rises to more than 10,000 residents per square mile.

[13] Ibid.

[14] Ibid.

EXHIBIT 4: POPULATION DENSITY



SOURCE: U.S. Census Bureau

2.1.2 Provider landscape

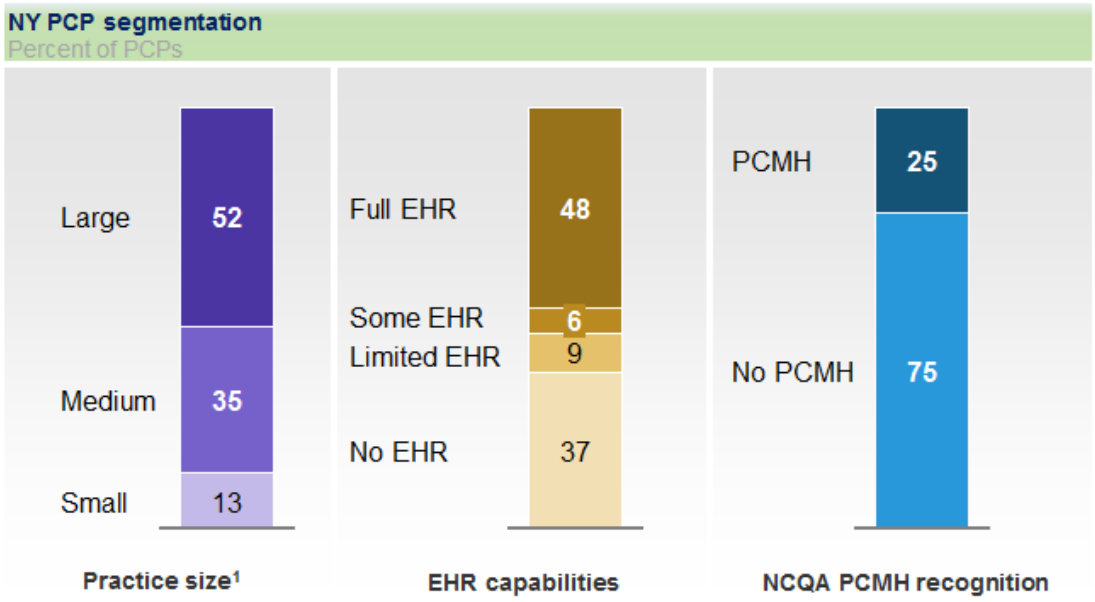
The provider landscape in New York points to a strong foundation for the statewide shift to an Advanced Primary Care (APC) model. New York has the fourth-highest ratio of physicians to residents in the nation, behind the District of Columbia, Massachusetts, and Rhode Island. The State has approximately 360 physicians per 100,000 residents, compared to an average of 271 per 100,000 across the country. We have 40 percent more specialists per capita than do other states and 22 percent more primary care physicians per capita than average.[15]

Although most primary care providers in the State still operate in small practice sites and one-third of all practices have neither any form of EHR or NCQA recognition, approximately 85 percent have some degree of affiliation with hospital systems, medical groups, independent practice associations (IPAs), or other organizational forms that could provide a foundation for building or purchasing more advanced capabilities in the coming three to five years. Exhibit 5 shows the estimated distribution of primary care physicians by practice size and

[15] Kaiser State Health Facts,: State Licensing Information from Redi Data, Inc., November 2012.

capabilities; Exhibit 6 shows how these features intersect within practices. Encouragingly, these distributions reflect a landscape of practitioners that could have a relatively high degree of "readiness" to shift from traditional forms of primary care practice to more advanced models of integrated care. Nearly 80 percent of primary care providers have some advantageous mix of scale, electronic health record (EHR) capabilities, and/or PCMH recognition. Nearly half have at least medium-sized practice scale and some degree of functional EHR capability; of those, nearly 40 percent have NCQA PCMH recognition. Indeed, as physicians increasingly choose hospital employment or medical group membership over independent practice, the pool of providers "ready" for the transition will only continue to grow. There has also been a trend toward consolidation among medical groups over the past five years, as the total number of medical groups fell 17 percent while the average number of physicians per medical group increased from 21 to 30.[16]

EXHIBIT 5: PROVIDER SEGMENTATION



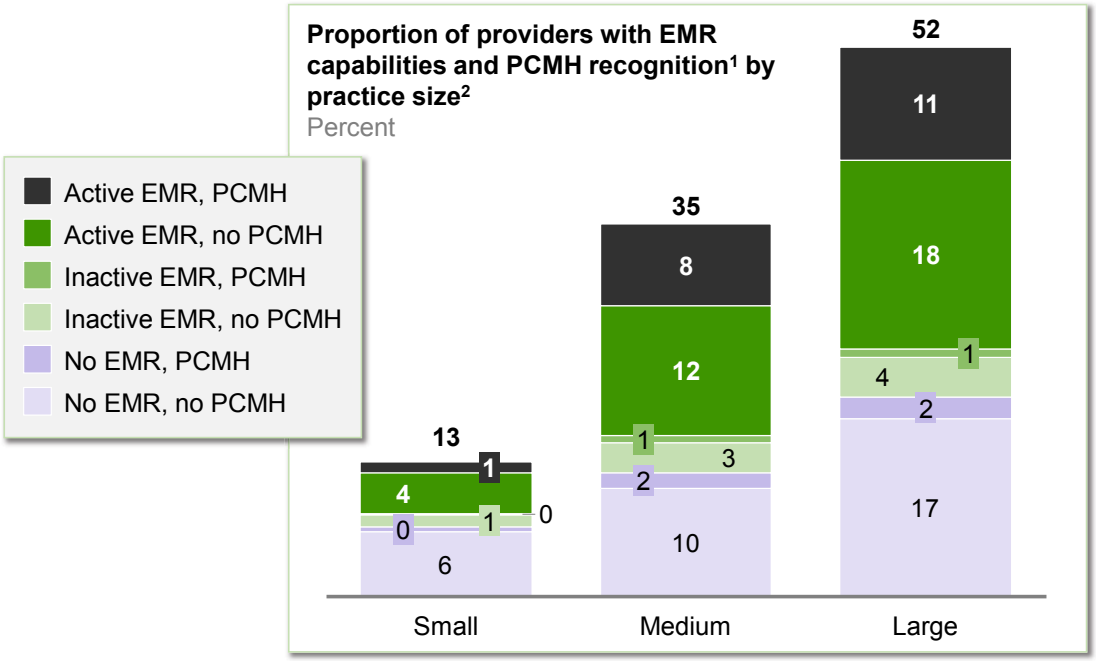
1 Practice size defined as follows: Large = 20+PCPS in a single practice OR an affiliation >100 PCPs; Medium = 4-17 PCPs in a single practice OR an affiliation of 20-100 PCPs; Small = 3 or fewer PCPs in a single practice AND an affiliation <20 PCPs

SOURCE: SK&A provider database, 2012 – estimated to cover 75-85% of New York providers

16 SK&A Physician Directory, 2008, 2013.

EXHIBIT 6: PRACTICE READINESS FOR INTEGRATED CARE

The intersection of EMR capabilities and NCQA PCMH recognition may be indicative of a practice's readiness for integrated care



1 Based on NCQA PCMH recognition 2 Practice size defined as follows: Large = 20+PCPS in a single practice OR an affiliation >100 PCPs; Medium = 4-17 PCPs in a single practice OR an affiliation of 20-100 PCPs; Small = 3 or fewer PCPs in a single practice AND an affiliation <20 PCPs

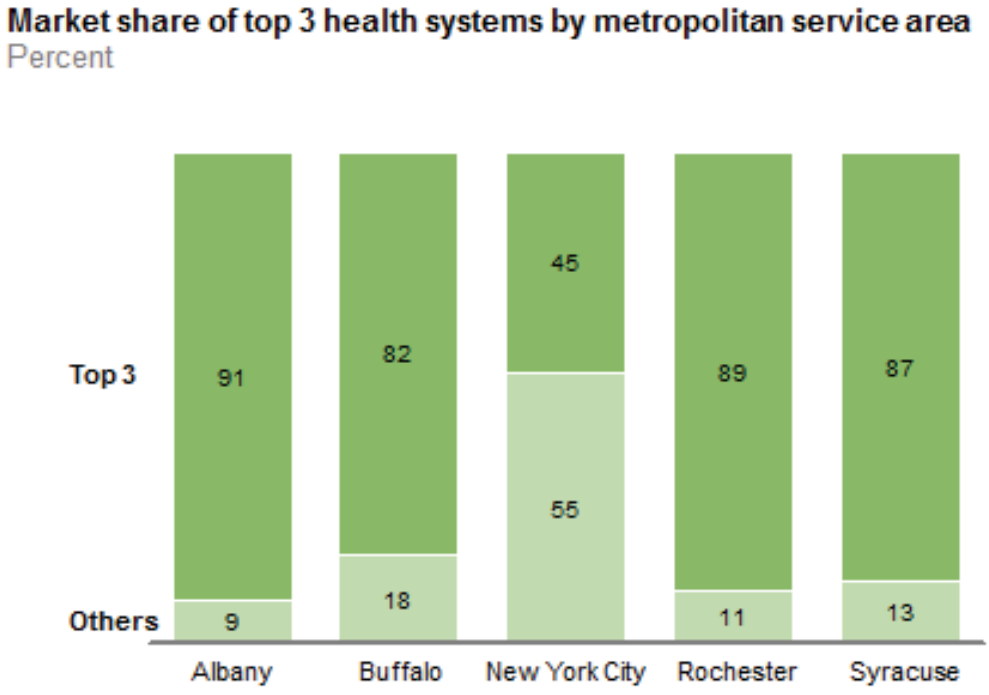
SOURCE: SK&A provider database, 2012 – estimated to cover 75-85% of New York providers

In relation to the acute care setting, Exhibit 7 shows the distribution of hospital systems across the state. There is a high degree of consolidation; in most markets, the top three largest health systems represent more than 80 percent of market share. In New York City, the top three account for 45 percent of share; the top six account for roughly 70 percent of all inpatient discharges.[17] Additionally, 31 percent of primary care physicians (PCPs) in New York have an affiliation with one of these large hospital systems.[18]

[17] HealthLeaders InterStudy New York City MSA Market Overview, 2013 based on Billian's HealthDATA, 2012; American Hospital Directory, Financial Compass 2012Q4.

[18] SK&A data, March 2013 and the American Hospital Directory.

EXHIBIT 7: HEALTH SYSTEM MARKET SHARE



SOURCE: HealthLeaders InterStudy New York City MSA Market Overview, 2013 based on Billian's HealthDATA, 2012; American Hospital Directory, Financial Compass 2012Q4

Importantly, however, the number of inpatient beds per 1,000 persons exceeds the national average by 15 percent.[19] Three out of 10 New York hospitals do not report positive profit margins,[20] and an increasing number are in material financial distress. An important component of the Plan will be helping to facilitate the necessary shift in industry structure and mitigating the challenges that inevitably accompany such structural changes. One role of Regional Health Improvement Collaboratives will be to facilitate local health planning to anticipate a community's future health needs and carry out strategies to enable the care delivery system to meet those needs.[21] As currently envisioned, 11 regional health planning entities would be enlisted to convene multiple stakeholders, and foster collaboration and cooperation for the purpose of advancing the Triple Aim in their respective communities.

[19] Kaiser State Health Facts.

[20] Financial Compass, 2010; American Hospital Association Annual Survey data, 2010.

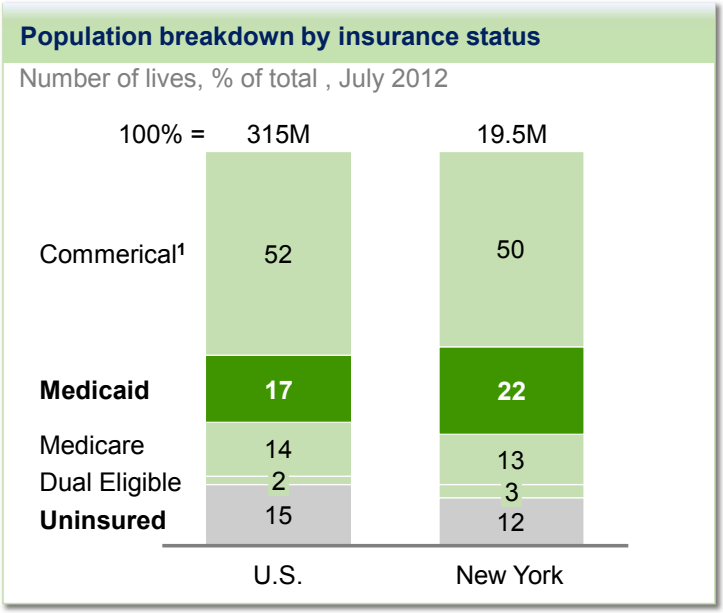
[21] New York State DOH.

2.1.3 Payer and Policy Landscape

At 12 percent, New York has a relatively small uninsured population as compared to other states.[22] Non-elderly adults represent the largest portion of the uninsured, and most children in poverty receive benefits. In fact, New York has the country's broadest eligibility for Children's Health Insurance Program (CHIP), at 400 percent of the federal poverty line.

EXHIBIT 8: POPULATION BY INSURANCE STATUS

New York State has a small uninsured population, with its Medicaid program serving a relatively large portion of the population



1 Includes TRICARE, residence for non-active/assigned unit for active duty (Medical)

SOURCE: HealthLeaders InterStudy Managed Markey Surveyor, July 2012

The proportion of New York residents covered by commercial payers and Medicare mirrors national trends (see Exhibit 8 above). For Medicaid coverage, however, New York has a much higher percentage of its population enrolled in the program than the national average (22 percent as of 2012).[23] As of spring 2013, the State had 5.4 million enrollees, roughly 25 percent of New York's 20 million residents. Altogether, including Medicare beneficiaries and dual

22 HealthLeaders InterStudy Managed Markey Surveyor, July 2012.

23 Kaiser State Commission on Medicaid and the Uninsured estimates based on Medicaid Statistical Information (MSIS) State Summary Datamarts, FY2010.

eligibles, the public sector insures about 38 percent of all New Yorkers, or 7.6 million lives.

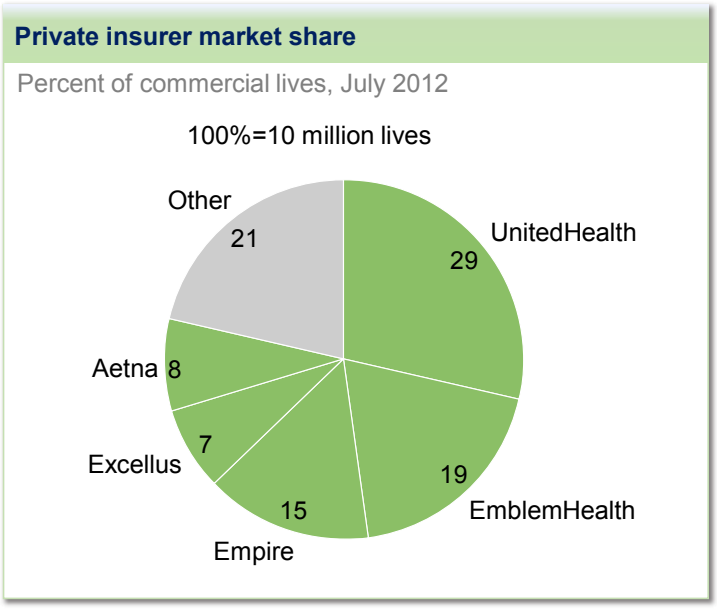
Commercial payers cover the remaining 10 million lives. New York's private health insurance landscape is complex, including large national payers, large regional players, and provider-owned health plans. Outside New York City, the leading health plan in each metropolitan market typically commands 30 to 50 percent of market share, and the three leading health plans typically account for approximately 65 to 80 percent of market share.[24] Within New York City, market share is more evenly divided with UnitedHealth, Emblem Health, and Empire BCBS reporting 27 percent, 19 percent, and 13 percent market share respectively. With the launch of the health insurance exchanges this past October, New Yorkers now have increased access to commercial health insurance plans.

The policy landscape in New York is diverse and evolving, marked by multiple new Governor-led initiatives intended to ensure the overall health and well-being of all New Yorkers. These initiatives range from Regional Economic Development Zones to the Fresh Connect program, which brings fresh food from New York farms to underserved communities throughout the State. Regional health planning to implement the Plan will include, leverage, and build on these initiatives to promote health and well-being, support the health care industry as an important driver of local economies, and ensure population health through good food, exercise and access to needed primary and preventive care.

[24] HealthLeaders-InterStudy, Market Overviews for Albany, Buffalo, Rochester, and Syracuse, 2012.

EXHIBIT 9: PRIVATE INSURER MARKET SHARE

Commercial insurance market is concentrated, with the top 5 players accounting for ~80% of all covered lives



SOURCE: HealthLeaders InterStudy Managed Market Surveyor, July 2012

2.2 HEALTH SYSTEM PERFORMANCE

On basic health outcomes, New York State's performance clusters around the national average. For instance, our population-level performance on rates of low birth weight and infant mortality are average; our rates of suicide deaths and cancer deaths are better than average. However, our heart disease deaths are worse than the national average, suggesting that we have gaps to close, especially in diseases related to obesity and unhealthy lifestyles (see Exhibit 10).[25] Our performance on these outcomes will be the product of our capacity to improve health by reducing the prevalence of risk factors that promote these diseases and our capacity to provide quality care, both at a cost that is sustainable for consumers and society.

[25] CDC, National Vital Statistics Reports (age adjusted data); cancer deaths includes malignant neoplasms only.

EXHIBIT 10: HEALTH OUTCOMES OVERVIEW

New York's health outcomes cluster around the national average

Health outcomes, 2010

	New York	U.S.	Best state	Healthy people 2020
Low birth weight as % of births	8.2%	8.1%	5.7%	7.8%
Infant mortality per 1,000 live births	5.1	6.2	3.8	6
Heart disease deaths per 100,000	199.9	179.1	119.4	NA
Suicide deaths per 100,000	7.8	12.1	7.7	10.2
Cancer deaths per 100,000	163.1	172.8	133.7	160.6

SOURCE: CDC, National Vital Statistics Reports (age adjusted data); cancer deaths includes malignant neoplasms only

2.2.1 Population health status

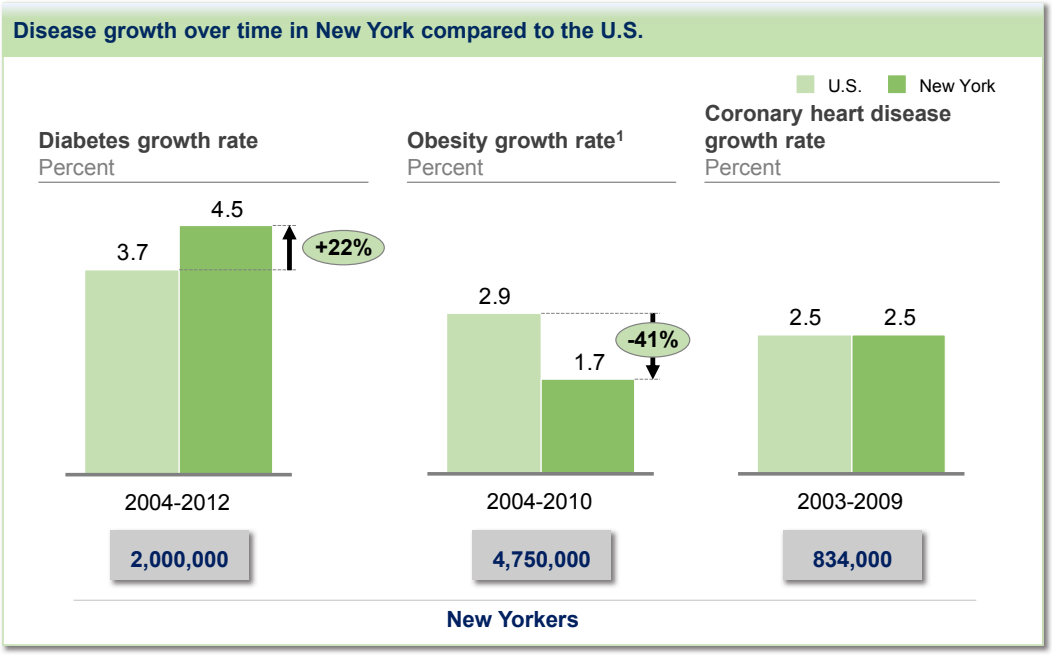
New York's population shares the challenges of the US population as a whole. In particular, diabetes rates exceed the national average. Our obesity rates fare slightly better than the national average but are nonetheless increasing. Our rates of coronary heart disease are as significant for us as they are for the nation overall (see Exhibit 11 below).[26] Considering chronic diseases on the whole, 23 percent of our population either has diabetes, cardiovascular disease, and/or asthma. Although only slightly exceeding the U.S. median of 22 percent, this remains a substantial challenge for New York State.[27]

[26] Behavioral Risk Factor Surveillance System: Prevalence and Trends Data; CDC: Division for Heart Disease and Stroke Prevention: Data Trends and Maps.

[27] SHADAC analysis of Behavioral Risk Factor Surveillance System (BRFSS). Disease prevalence measure includes people who report having more than one of these diseases.

EXHIBIT 11: CHRONIC DISEASE GROWTH

Chronic disease prevalence is growing in New York as in the U.S. as a whole



1 BMI>30

SOURCE: Behavioral Risk Factor Surveillance System: Prevalence and Trends Data; CDC: Division for Heart Disease and Stroke Prevention: Data Trends and Maps

More than one out of every 10 New Yorkers now live with diabetes, which in turn drives coronary heart disease. Almost one-quarter of New York's adult population is obese while another 36 percent are overweight. Obesity—a significant risk factor for Type 2 diabetes, asthma, high blood pressure, high cholesterol, stroke, heart disease, certain types of cancer, and osteoarthritis—will soon overtake tobacco as the leading preventable cause of death in the U.S. This trend is already being replicated in New York's next generation, with some 36 percent of school-age children overweight. Our prevention activities for these chronic conditions clearly have room for improvement. The state's overall performance on preventive care for adults is only second quartile, as are our prevention efforts against diabetes specifically.[28] As of 2011, nearly 80 percent of New Yorkers were not meeting physical activity recommendations.[29]

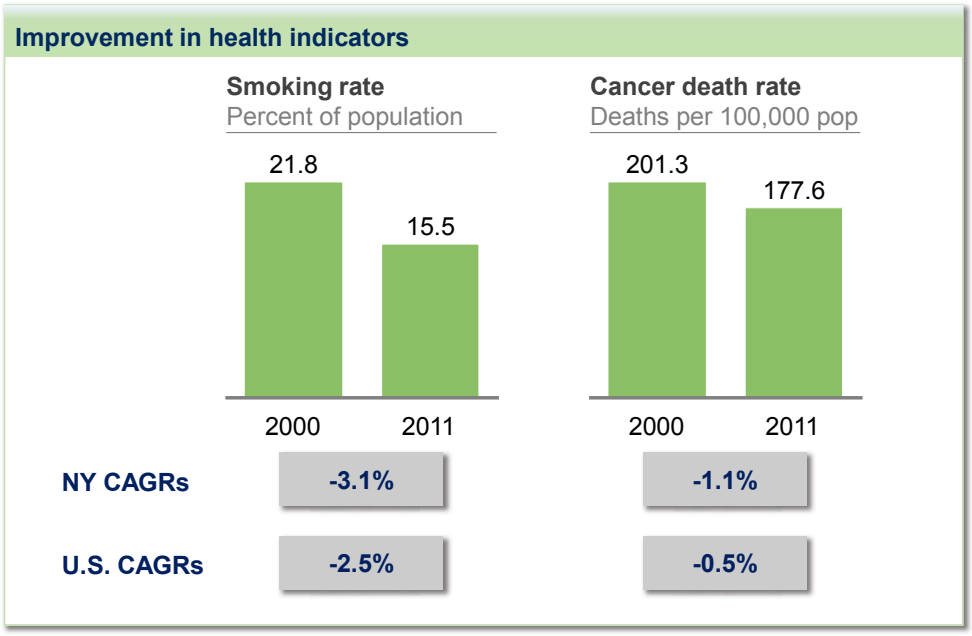
[28] Health System Data Center, 2009 and 2011 Scorecards. The Commonwealth Fund, http://datacenter.commonwealthfund.org/scorecard/state/34/new-york/. Accessed 26 October 2013.

[29] Youth Risk Behavior Surveillance System (YRBSS).

Although we struggle with preventing chronic conditions like obesity, diabetes, and heart disease, we have seen improvements in other areas since 2000. We scored in the first quartile with regard to routine immunization, medical, and dental care for children,[30] an accomplishment among Medicaid enrollees that has been significantly influenced by the transition to managed care plans. And, as demonstrated in Exhibit 12, we have made headway on tobacco use and cancer. These results were achieved through targeted campaigns, including an aggressive State excise tax to tackle smoking and widespread, intensive cancer screening to reduce the cancer death rate.[31] Still, gaps remain. For instance, we are in the third quartile in colorectal cancer screening.[32]

EXHIBIT 12: PREVENTION OUTCOMES

Some prevention programs have led to state-wide improvement in health outcomes and risk factors above and beyond those achieved nationally



SOURCE: New York State Dept of Health: Suicide - Death and Death Rates; America's Health Ranking: New York Smoking, Cancer deaths; CDC data via American Foundation for Suicide Prevention

[30] Ibid.

[31] America's Health Ranking: New York Smoking, Cancer deaths; CDC data via American Foundation for Suicide Prevention.

[32] CDC Health Disparities and Inequalities Report — United States, 2011, CDC MMWR (14 January 2011),

Therefore, our population health track record suggests that we have room for improvement across multiple dimensions. More specifically, we should redouble our focus on chronic illness prevention efforts through clinical preventive services and the use of broader strategies that build community environments that promote healthier choices.

2.2.2 Health care quality performance

Reducing avoidable hospital admissions and readmissions is a key objective for many of our health care reform efforts. Our performance on ambulatory care-sensitive admissions is at the bottom quartile for both adults and children (over 8 percent and 45 percent greater than the national average, respectively[33]), and average readmission rates for three conditions—heart failure, heart attacks, and pneumonia—are 25 percent higher than the national average.[34] The Commonwealth Fund State scorecard for 2009 ranked us 50th for performance on avoidable hospital use and 47th in 30-day readmissions.[35] Other measures of quality further support the need for improvements. For instance, medication compliance averages 67 percent.[36]

Indicators of how effectively we are dealing with chronic disease and mental illness also reveal room for improvement. One in 10 patients hospitalized for heart attack, heart failure, or pneumonia did not receive recommended care, compared to 1 in 20 for the highest-performing state.[37] Adult New Yorkers living with chronic obstructive pulmonary disorder (COPD) are nearly twice as likely to be hospitalized for their condition compared to COPD patients across the U.S.[38] Meanwhile, diabetic children in New York are 7 percent more likely to be hospitalized for short-term complications than the U.S. average for their peer group.[39] Finally, the State has yet to achieve the best practice outcomes in the

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[33] Healthcare Cost and Utilization Project (HCUP) data. Potentially preventable hospitalizations calculated using the Agency for Healthcare Research and Quality and Pediatric Quality Indicators.

[34] CMS Readmission Reduction program data files.

[35] Health System Data Center, 2009 and 2011 Scorecards. The Commonwealth Fund, http://datacenter.commonwealthfund.org/scorecard/state/34/new-york/. Accessed 26 October 2013.

[36] *State of the States: Adherence Report*, CVS Caremark, 2012. Includes members of CVS Caremark pharmacy benefit management program taking medications for diabetes, high blood pressure, high cholesterol and depression.

[37] Health System Data Center, 2009 and 2011 Scorecards. The Commonwealth Fund, http://datacenter.commonwealthfund.org/scorecard/state/34/new-york/. Accessed 26 October 2013.

[38] Department of Health, New York State: Indicators for Tracking Public Health Priority Areas.

[39] Ibid.

important area of mental health. We estimate that only about 25 percent of patients with depression and other low-acuity mental health conditions receive effective care.[40] Only 20 percent of adult patients with mental health disorders are seen by mental health specialists.[41]

At the same time, however, certain Medicaid outcomes surpass national averages. For example, more than 65 percent of New York Medicaid HMO members with diabetes have appropriate blood pressure levels, compared with around 60 percent nationwide.[42]

2.2.3 Patient experience

Currently, New York's patient experience falls below our aspirations. Across the state, patients report that their overall experience is, at best, "average," and waiting times are consistently above national averages. Specifically, surveys indicate that our citizens across the State typically wait six hours before being admitted as an inpatient from the Emergency Department, more than 1.5 hours longer than the national average. In New York City, the average reported wait time was 10.5 hours, [43] more than twice the national average.

Patient experience with primary care physicians (PCPs) is also not yet meeting our goals. Sources report mixed performance. Consumer Assessment of Healthcare Providers and Systems (CAHPS) data aggregated to the State level suggests that patient satisfaction rates are greater than 50 percent.

Fundamental to quality care is access to care. While we have above-average health insurance coverage (88 percent compared to 84 percent nationally), we are not top decile (91 percent).[44] Today, we estimate that 2.7 million New Yorkers under age 65 do not have a health insurer. Beyond the issue of coverage is the simple provision of timely and quality care to all, without disparity. Here, too, we can do better. In 2010, more than 1 in 15 New Yorkers who needed to see a provider delayed their care due to cost.[45]

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[40] Health Home Information Resource Center, May 2013. Center for Health Care Strategies and Mathematica Policy Research for the Centers for Medicare & Medicaid Services.

[41] Ibid.

[42] State of Health Care Quality (NCQA), March 28, 2013.

[43] CMS: Hospital Compare.

[44] SHADAC analysis of American Community Survey (ACS).

[45] NCHS analysis of the National Health Interview Survey (NHIS).

EXHIBIT 13: HEALTH SYSTEM TIMELINESS

All health systems fall short of timeliness national targets

Outperforms U.S. average
Close to the U.S. average
Underperform U.S. average

	New York City		Albany		Syracuse		Buffalo		Rochester			
	NYP	NSLIJ	St Peter's	Albany Med Center	Upstate University	St Joseph's	Kaleida	Catholic Health	Univ. of Rochester	Rochester General	NY Avg	National average
Patients who reported they would recommend the hospital	80%	77%	74%	69%	69%	78%	64%	72%	79%	76%	65%	70%
Patients who gave their hospital a rating of 9 or 10	74%	72%	65%	59%	64%	74%	58%	67%	72%	72%	61%	69%
Average time before patients with chest pain/heart failure got ECG	N/A	N/A	N/A	N/A	9	N/A	N/A	13	N/A	N/A	9	7 minutes
Time patients spent in ED before admission as an inpatient	631[2]	356[2]	382[2]	373[2]	358[2]	454[2]	384[2]	335[2]	521[2]	378[2]	363	277 minutes

1 Performance measures reported by the largest hospital within the health system, by 2011 total discharges
2 Hospital indicated that the data submitted for this measure was based on a sample of cases

SOURCE: CMS: Hospital Compare

2.2.4 Cost performance

New York's health care spending per capita is 22 percent greater than the national average, and this gap has been increasing over time. Since 2000, the absolute variance between New York's per capita spend and the national average has increased by nearly 60 percent.[46]

Medicaid, covering one-quarter of New York's 20 million residents, has historically been a significant driver of our high health care spending relative to other states. Medicaid spending per enrollee – $8,900 – is the second highest among Medicaid programs and about 55 percent more than the average per capita spent on Medicaid nationwide. Although some of the state's higher than average per capita Medicaid expenditure can be attributed to New York's greater provision of Medicaid benefits, the State has also had excessive spending on preventable hospital admissions and readmissions.[47] In addition, although eligibility requirements are comparable to those of peer states [48]—New Jersey,

[46] Centers for Medicare & Medicaid Services: Health Expenditures by State of Residence, 2011.

[47] Hospital Admissions for Ambulatory Sensitive Conditions and Subsequent Potentially Preventable Readmissions in the Medicaid Population in New York State, 2007.

[48] Kaiser Commission on Medicaid and the Uninsured, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013.

Massachusetts, Connecticut, and Pennsylvania—New York ranks fifth among all states in terms of the proportion of the population on Medicaid. New York's per capita health expenditures excluding Medicaid ($7,600), are 12% higher than the U.S. average. In addition, premiums in the employer-sponsored market are approximately 10 percent higher than the national average. In the individual insurance market, they were more than 60 percent higher (prior to the health insurance marketplace).[49]

New York's high per capita costs appear to stem from three core drivers: higher-than-average **unit costs**; high **avoidable utilization (through cost drivers such as** end-of-life expenditures); and—cutting across the first two levers—a small set of highly **complex populations** with health care costs that are not yet being effectively managed.

- **Unit costs.** Although comprehensive unit cost data is not available for intra- or interstate comparison, emerging evidence suggests that unit costs in our State are substantially higher than the national average. For example, health care spending on hospitals is approximately 19 percent higher in New York than the national average.[50] The cost at discharge for a patient who has had a heart attack is roughly $30,300 compared with the nation's average of $25,100.[51] Significant variation among hospitals in operating efficiency appears to contribute to the broader unit cost opportunity; internal hospital operating expense per discharge ranges from $10,000 to $30,000 for comparable case mixes across New York hospitals.[52]
- **Avoidable utilization.** Relative to other states, New York ranks 50th in terms of avoidable hospitalizations[53] and 40th in terms of ambulatory care-sensitive admissions,[54] suggesting that too much care is taking place in high-cost hospital settings rather than in more efficient outpatient settings, and that our primary care services could be better leveraged to reduce the frequency of acute events. An example of high utilization is in end-of-life care. End-of-life expenditures outpace those in other states. In 2007, New York State averaged

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[49] Kaiser State Health Facts analysis of data from the Mark Farrah Associates, and Dartmouth Atlas of Healthcare.

[50] CMS Medicare Provider Analysis and Review (MEDPAR) inpatient data, FY 2011.

[51] AMI discharged alive with complication or comorbidity. CMS Medicare Provider Analysis and Review (MEDPAR) inpatient data, FY2011.

[52] Financial Compass 2010 Data. Adjusted using Case Mix Index to account for severity-of-illness differences between hospitals.

[53] New York State, Healthcare Medicaid Redesign Waiver FAQs, www.health.ny.gov.

[54] Commonwealth Fund, Health Systems Data Center.

$22,000 in inpatient spending per decedent in the last six months of life, as compared with $15,000 nation-wide.[55]

- **Complex populations.** Keeping with national trends, it is estimated that high-risk, high-cost populations comprise 10 percent of New York's population but 60 percent of overall health care expenditures. For example, Medicaid spending on children and non-aged adults is in line with national averages,. But spending on disabled enrollees is the highest in the nation, and spending per aged enrollee is the fourth-highest in the nation, accounting for a significant share of the 22 percent difference in Medicaid per-capita spend relative to the national average. [56]

As this section highlights, New York State has room for improvement in each part of the Triple Aim. However, as the next section describes, we also have a roster of emerging strengths that provide the foundation for the Plan.

[55] Dartmouth atlas of health care, 2007.

[56] High-Risk, High-Cost patients are considered to be those classified by CareFirst as Catastrophic Conditions (Band 1) and Multiple Chronic Conditions (Band 2).

3. Emerging Strengths and Innovations

New York State has a number of strengths and innovations that will be leveraged as we begin a concerted, statewide health care transformation. These strengths, which align with the key pillars of the Plan, include:

- A track record of supporting health services for all, without disparity, and groundbreaking efforts to expand health insurance coverage
- Significant experience with integrated care delivery approaches
- Efforts to promote transparency for all—from consumers to providers to local and State agencies—who have a stake in the health system
- Broad-based provider and payer participation in value-based payment approaches
- State-level support and local partnerships to enhance population health and prevention efforts

New York's critical supporting enablers—health care workforce strategy, health information technology (HIT), and measurement and evaluation—also represent areas in which we have invested heavily to date. Foundational planning and programming have been underway for each area.

New York State has the organizational structure and experience to coordinate and implement statewide efforts of this scale and scope. While we realize that implementation will not be easy, we are confident that we can build on our past successes to carry out major initiatives that affect all New Yorkers and coordinate efforts involving broad stakeholder involvement.

3.1 STRENGTHS AND INNOVATIONS

3.1.1 Support of health services for all

New York has a proud history of championing health access for its citizens of all backgrounds and means. We have a strong network of federally qualified health centers, which is also a vanguard of medical homes and HIT-enabled primary care.

We have a robust, nationally recognized regional health planning efforts, exemplified by health systems agencies (HSAs), including Finger Lakes HSA, which coordinates efforts across the care delivery system and community. And we have a forward-looking State Medicaid program, which has not only saved billions of dollars through its recent Medicaid Redesign Team (MRT) but has also developed models to improve the care of special populations. These models of care impact those with complex and chronic conditions such as mental illness and

substance abuse, as well as persons with disabilities who require supportive care. The Medicaid program also heavily supports safety-net providers, who serve vulnerable populations across the State and in particular in the downstate region. Its planned Delivery System Reform Incentive Programs (DSRIP) will further support safety-net providers as they transform their care delivery models to better serve all without disparity.

In addition, the State has taken a groundbreaking step toward enabling health insurance coverage for New Yorkers. The recently launched NY State of Health marketplace offers affordable coverage to all New Yorkers, including approximately 2.7 million New Yorkers under 65 who do not have coverage today. The marketplace is expected to secure coverage for more than 1 million individuals and small-business employees. In fact, as of December 9, 2013 314,416 New Yorkers had completed applications and more than 100,000 New Yorkers had enrolled in a health plan through the NY State of Health (https://nystateofhealth.ny.gov/)

3.1.2 Experience with multi-payer advanced primary care delivery approaches

Innovation through advanced primary care (APC) delivery models has been ongoing for years in several regions of New York State. Examples include the Adirondack Region Medical Home Pilot, the Finger Lakes Health Systems Agency, and the Rochester Medical Home project. All are examples of self-directed innovation by New York stakeholders—providers, payers, and others—and demonstrates the State's experience with these types of care delivery models.

The State has also supported patient-centered medical home (PCMH) development through the Medicaid-based PCMH Incentive Program and the Hospital-Medical Home Demonstration, both enabled by significant support from CMS. The PCMH Incentive Program provides a per member per month (PMPM) financial incentive to primary care practices that attain NCQA PCMH certification. Since the program was introduced in 2010, it has disbursed $148 million to almost 4,500 participating physicians serving 1.6 million Medicaid beneficiaries. The Hospital-Medical Home Demonstration is a health care quality and safety improvement program that will provide up to $250 million to the State's teaching hospitals to improve care in NCQA-certified sites with primary care residency training programs. The demonstration has reached 62 teaching hospitals and 119 primary care residency programs in 162 outpatient primary care sites.

In addition, multiple health systems in the State are participating in programs sponsored by the Center for Medicare & Medicaid Innovation. These programs include, but are not limited to:

- Capital District-Hudson Valley Comprehensive Primary Care initiative: a coalition of 74 primary care practices, 287 providers, and six payers working together to test a multi-payer advanced primary care model
- Montefiore Pioneer Accountable Care Organization Model: one of 32 institutions nationwide selected in 2011 to participate in a model that provides Medicare beneficiaries with high-quality care while reducing expenditures through better care coordination; it has generated $14 million in savings in its first three years
- Health Care Innovation Awards: awarded to 13 New York institutions implementing the most compelling new ideas to deliver on the Triple Aim, including:
  - The Bronx Regional Health Information Organization, to develop data registries and predictive systems to proactively encourage early care interventions
  - The Development Disabilities Health Services health home model
  - The Finger Lakes Health System Agency, to establish a community-wide outcomes-based payment model for primary care
  - The Fund for Public Health in New York, to implement interventions for people with serious mental illness
  - Mount Sinai School of Medicine, to integrate geriatric care with emergency department care
- Bundled Payments for Care Improvement Initiative: awarded to 24 organizations within the State to implement payment arrangements that include financial and performance accountability for episodes of care
- Community-based Care Transitions Program: awarded to 12 New York sites to test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries
- FQHC Advanced Primary Care Practice Demonstration: awarded to nine organizations across 14 sites to test how the patient-centered medical home model can improve quality of care, promote better health, and lower costs

In addition, the Office of Primary Care and Health Systems Management is conducting an assessment of the wide array of care settings in which primary care is delivered (for instance, urgent care centers and freestanding emergency care centers). The hope is to better understand and provide guidance for how these alternative points of access may best work within the broader care delivery system and to ensure that they, too, are effectively connected to future HIT and integrated with other sites of care.

Overall, these examples demonstrate that care delivery innovations abound in New York State, which already has a proactive and established groundwork that will catalyze further, comprehensive system reform.

3.1.3 Recent efforts to promote transparency

The State has embarked on multiple efforts to increase the health system's transparency for stakeholders, especially for consumers. The NYS Open Data initiative makes the wealth of public data generated by various New York agencies available for public use. CMS recently awarded New York a Cycle III grant to enable the development of infrastructure and models to integrate cost and quality performance data for public consumption and for the Rate Review process. Multiple commercial payers have also assumed the mantle of transparency through plan-based patient portals and reports. They are increasingly bringing quality data to consumers in order to inform their decision making.

Lastly, the State has precedent on its side when it comes to engaging consumers: its historical, targeted health promotion campaigns for HIV/AIDS, smoking and tobacco are widely recognized as best practice examples of how to use data to empower consumers to improve their health.

3.1.4 Broad-based participation in value-based payment approaches

Value-based payment approaches have been tested across many settings in New York State, by a variety of stakeholders including local collaboratives and the Department of Health, and through federally-sponsored initiatives.

For example, the Adirondacks PCMH, through the Medicare Multi-payer Advanced Primary Care Practice demonstration, delivers upfront payments on a PMPM basis to support practice transformation to a medical home model, care management, transitional care, and the active use of data to improve care. The Capital District-Hudson Valley-Comprehensive Primary Care initiative implements a multi-payer model with both upfront care coordination fees and gain-sharing of savings achieved by the practices.

At the State level, Medicaid, through its Medicaid Redesign Team (MRT), has multiple cost-saving initiatives that are coupled with comprehensive measurement to promote quality processes and outcomes. For instance, New York is implementing (a) the Fully Integrated Duals Advantage (FIDA) demonstration, which will transition 170,000 dually-eligible beneficiaries into new managed care programs, and (b) the Behavioral Health Managed Care Design program to transition individuals with significant behavioral health needs into managed care plans called Health and Recovery Plans. The Medicaid PCMH Incentive Program, discussed above, also provides tiered PMPM payments to Medicaid providers who

are NCQA PCMH-recognized with incentives to 'upgrade' recognition to newer, more challenging, standards.

Commercial payers have been exploring value-based payment approaches, too. In fact, nearly every major statewide and regional payer has tested some form of a pay-for-performance approach, and many have tried gain-sharing, two-sided risk-sharing, or capitated approaches as well.

These experiences with value-based payment have primed the provider and payer landscape for further concerted payment innovations. They also provide important, empirical insights as to what works and what does not, including the need for upfront financial support to fund transformation for certain practices and the need for standardized approaches to measurement, evaluation, and reporting. We know for instance, that standardization reduces complexity for providers and improves the business case for provider investment in new capabilities and practice pattern changes.

3.1.5 Enhanced statewide population health and prevention efforts

NYS has a wide range of ongoing initiatives to drive improvement in population health status across the State. The NYS Prevention Agenda 2013-2017 is at the center of these efforts. With the Agenda, New York has identified the State's most urgent health concerns and suggested ways local health departments, hospitals, and partners from health, business, education, and nonprofit organizations can work together to solve them. The Agenda has five overarching process goals:

1. Improve health status in five selected priority areas and reduce health disparities for racial, ethnic, disability, socioeconomic, and other groups who experience them
2. Promote attention to the health implications of policies and actions that occur outside of the health sector, such as in transportation, community and economic development, education, and public safety
3. Create and strengthen public-private partnerships to achieve sustainable health improvement at State and local levels
4. Increase investment in prevention and public health to improve health, control health care costs, and increase economic productivity
5. Strengthen governmental and non-governmental public health agencies and resources at State and local levels

In addition, the Agenda identifies five priority action areas: chronic disease prevention; healthy and safe environments; healthy women, infants, and children; mental health and substance abuse prevention; and the prevention of HIV, sexually

transmitted diseases, vaccine-preventable diseases, and health-associated infections.

The Agenda roadmap has rallied community stakeholders on common goals, strategies, and measurements for population health and prevention efforts in the coming years. The Commissioner has directed local health departments and hospitals to work together with other stakeholders to assess the community's health, identify priorities and agree on a plan to tackle at least two of the Prevention Agenda priorities and one area of health disparity. These plans were due in mid-November and provide a base upon which the statewide care delivery model can link activities to streamline health care delivery with focused community health action on the same problems.[57]

Additionally, in 2013, Governor Cuomo launched the Community, Opportunity, and Reinvestment (CORe) initiative to increase the well-being of communities. This initiative will identify areas with significant economic and social needs, and assist these communities in significantly improving measurable quality of life outcomes; build alignment and partnerships between public, private, and community organizations to coordinate resources and solutions; and further support communities that exhibit a readiness to partner across sectors and incorporate new strategies. CORe goals include: reducing crime; supporting education and employment opportunities to address poverty; supporting and producing a skilled workforce with access to jobs; strengthening local linkages; improving health at all ages; improving educational outcomes; reducing disparities in outcomes related to human service access; and ensuring access to safe and affordable housing.[58]

3.2 FOUNDATIONAL EFFORTS ON CRITICAL ENABLING ELEMENTS

3.2.1 Health care workforce strategy

New York State is a locus of health care workforce education and training, with extensive clinical education programs that graduate 30 percent more residents per year than any other state. It is also home to 16 medical schools, 19 programs for physician assistants, 83 nursing programs, and 87 teaching hospitals that attract talent from around the world.

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57 http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm.

58 New York Association of Psychiatric Rehabilitation Services, Inc. NYS Community, Opportunity, & Reinvestment Initiative Seeks Interested Groups, October 10, 2012.

The current portfolio of workforce initiatives may potentially be reinforced by up to $500 million in funding over five years from the pending MRT 1115 waiver amendment. The Waiver initiatives will focus on multiple critical issues:

- Addressing underserved areas by increasing physician supply appropriate to the needs of the communities and recruiting non-physician primary care providers in those areas
- Building capabilities through the Health Workforce Retraining Initiative and technical assistance programs that seek to train an array of existing health workers to take on responsibilities attached to new care models
- Supporting health services research to understand the effectiveness of different health workforce staffing models, including the development of a Health Workforce Data Repository to support ongoing collection, analysis, and dissemination of health workforce data

3.2.2 Health information technology

The State has an active, robust HIT agenda that will enable effective scale-up and implementation of integrated, value-based care. The future APC model is grounded in these expanded HIT capabilities. The HIT agenda, which will also help open up new frontiers of transparency on quality and cost, will empower consumers, providers, payers, and communities to make informed, value-based decisions system-wide.

The development of an All-Payer Database (APD) is underway, and the health information exchange (HIE) is gaining traction through Regional Health Information Organizations and at an even broader level through the Statewide Health Information Network of New York (SHIN-NY). These networks will enable unprecedented data flows across the health system. Rigorous analytics and reporting will facilitate smart decision making by providers and consumers to navigate their medical neighborhoods; by communities to inform fact-based local health planning; by payers to design and implement value-based payment models; and by the State to provide population-level insights for its leadership across stakeholders.

Additional efforts further reinforce these possibilities. The recent Cycle III grant will facilitate the Rate Review process that will enable the Department of Financial Services to align value-based plans across payers and recognize payers' efforts to enable APC models of care, consistent with the objectives of the Plan, and generate data to empower consumers for both independent and shared decision making with providers.

Finally, the Patient Portal initiative will put personal health information in consumers' hands. EHR interoperability standards will strengthen future health

information flows by standardizing data platforms and connectivity across the State. New York State has been a leader among 18 states shaping these standards.

3.2.3 Performance measurement and evaluation

Robust measurement and evaluation of the State's progress toward the Triple Aim will be critical at all levels—State, community, payer, 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.

DOH has been evolving a process to develop standard metrics to measure health system performance on population health, quality care delivery, and cost performance, with the Office of Quality and Patient Safety (OQPS) leading these efforts. The Quality Assurance Reporting Requirements (QARR) —initiated in 1995 and required across commercial HMOs and PPOs, Medicaid managed care, and Child Health Plus—demonstrate the State's commitment to simplifying and standardizing health system and performance management. The Prevention Agenda metrics will also inform the State's understanding of health across its communities.

The measurement strategy of the MRT demonstrates a similar spirit of building on national standards and creating common approaches. The MRT evaluation plan established two series of quality indicators: Medicaid Quality of Care Measures and New York State Population Health Indicators. These initiatives will measure Medicaid's progress toward its performance goals over the next decade.

The QARR and MRT measurement approaches are just two examples of comprehensive, evidence-based evaluation programs that the State has supported. Others include those implemented at the Capital District-Hudson Valley-Comprehensive Primary Care initiative, the self-determined measurement approach of the Adirondacks PCMH program, and those designed to evaluate the Prevention Agenda. All are grounded in accepted, nationally recognized measurement approaches—such as Healthcare Effectiveness Data Information Set, National Quality Forum, and Children's Health Insurance Program Reauthorization Act—to allow benchmarking to national results.

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. As discussed above, public reporting will be enabled through the future Patient Portal and Cycle III transparency website for system and provider quality and cost performance. Systems that aggregate data across payers will be developed and rolled out with careful thought regarding competitive dynamics.

3.3 LEADING LARGE, MULTI-STAKEHOLDER EFFORTS

The MRT and the Prevention Agenda 2013–2017 are two recent examples of significant, multi-stakeholder health planning and implementation efforts that exemplify New York State's capacity to think big and execute swiftly.

Governor Cuomo, upon taking office in January 2011, established the MRT, with a mandate to address underlying health care cost and quality issues in New York's Medicaid program. The MRT successfully crafted a first-year Medicaid budget proposal and developed a multi-year reform plan through a process that involved key Medicaid stakeholders from across the health system. As a result, Phase 1 provided a blueprint for lowering Medicaid spending in FY2011–12 by $2.2 billion—and by $34.3 billion over five years—which resulted in 78 distinct initiatives by the end of February 2011. In Phase 2, the MRT developed a multi-year action plan to reform the Medicaid program. The MRT has also produced a groundbreaking pending Medicaid 1115 Waiver amendment that aims to allow New York State to reinvest in its health care infrastructure, including 13 discrete cost areas related to new care models, enhancing primary care, fostering inpatient hospital transitions to outpatient networks, advancing HIT, and retraining the workforce.

The MRT is a national model for how stakeholders can work together to develop a comprehensive reform agenda, even during the most trying times. Similar coordinated, broad-based approaches were used when engaging stakeholders about NY State of Health, the State's health insurance marketplace, and about the development of health homes.[59]

The development of the Prevention Agenda 2013–2017 also demonstrates the State's capacity to organize statewide efforts for health improvement. The Agenda's goals were to establish a clear roadmap for public health stakeholders to follow. To design the plan, the New York State Public Health and Health Planning Committee convened 140 organizations from across the broad public health landscape, ranging from the NYS Business Council to major professional associations and health NGOs and advocacy groups. These experts and stakeholders from across the public health spectrum met to identify five priority action areas: chronic disease prevention; healthy and safe environments; healthy women, infants, and children; mental health and substance abuse prevention; and the prevention of HIV, sexually transmitted diseases, vaccine-preventable diseases, and health-associated infections.

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59 http://www.health.ny.gov/health_care/medicaid/redesign; http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf.

The Commissioner of Health has directed local health departments and hospitals to collaborate with each other and engage multiple stakeholders at the community level in shared community health needs assessments and community action plans. These efforts incorporate interventions requiring the active participation of a wide range of stakeholders, including community-based organizations, policymakers, employers, philanthropists, and community members. Community coalitions have been directed to work on two objectives among the five priority areas and one activity dealing specifically with a health disparity in their community as part of their plans. The DOH has provided support to this process through regional technical assistance programs and the provision of evidence-based examples of effective interventions and metrics that can be used to measure results. These plans are due to the State in November 2013 and, once approved, will permit the tracking of progress on selected health objectives across the State.

Furthermore, the State is well organized to enable cross-agency alignment. DOH already integrates important and adjacent areas of focus by housing together the Office of Health Insurance Programs (which manages Medicaid), the Office of Quality and Patient Safety (which leads on quality measurement and improvement), the Offices of Primary Care and Health Systems Management and the Office of Public Health. DOH also works closely with the Office of Alcoholism and Substance Abuse Services (OASAS) and the Office of Mental Health (OMH), through Medicaid, licensure reform, and behavioral health integration efforts. This organizational structure establishes the formal lines of communication critical to the comprehensive design and implementation of the State Health Innovation Plan. In addition, there has been increasing collaboration between DOH and other State agencies with large investments in health, including the Department of Financial Services (DFS) and the Department of Civil Service (DCS). DOH has partnered with DFS to develop infrastructure and approaches that will increase the transparency of cost and quality data to inform the Premium Rate Review process. DOH has also partnered with DCS to consider opportunities for the New York State Health Insurance Program, the State employees' health plan, to lead the way on care delivery and payment innovation, as well as value-based benefit design.

NYS has notable experience with value-based benefit design based on work by the MRT, which was charged with evaluating the Medicaid benefit package. In addition, NY will look to initiatives such as Choosing Wisely®, created by the American Board of Internal Medicine Foundation (ABIM) in 2012 with a goal of reducing overuse of tests and procedures, and helping patients, in consultation with physicians, make smart and effective care choices.

Altogether, the State has demonstrated success in organizing and executing broad, multi-stakeholder efforts, and is poised to capitalize on its past experiences and expertise as it implements its State Health Innovation Plan.

II. Strategic Pillars

1. Ensure Timely Access to Care

Timely, appropriate access is the cornerstone of quality health care and foundational to our State Health Innovation Plan. New York has a proud history of providing good access to care, with one of the lowest proportions of uninsured populations across the country.[60] However, we seek to go further to ensure access without disparity, inclusive of all populations across the State of any means, circumstance, background, or geography. Our ambition is to improve access and continue to be a leader in providing timely access to health care for all. Our approach toward doing so comprises four parts:

1. **Leverage consumer insights to increase adoption of health insurance coverage**
2. **Strengthen our safety-net providers that serve New York's most vulnerable populations, regardless of ability to pay**
3. **Increase workforce capacity in underserved regions of New York State**
4. **Make care more accessible through extended hours, open access scheduling, and use of technology**

1.1 LEVERAGE CONSUMER INSIGHTS TO INCREASE ADOPTION OF HEALTH INSURANCE COVERAGE

New York State of Health, our State health insurance exchange, went live on October 1st 2013, and early uptake and site traffic has exceeded expectations. Our goal is that the Marketplace results in more than 1 million individuals obtaining health care insurance over the first three years, including more than 350,000 consumers who did not have it previously. This represents an almost 15 percent reduction in the uninsured, and a reduction of 1 million New Yorkers once additions to Medicaid, CHIP, and other private payers are included.[61]

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[60] Commonwealth Fund, Health System Data Center, 2009 data.

[61] Uninsured New Yorkers After Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area, May 2013 revision.

The State understands that the long-term success of the Marketplace will depend on a combination of the availability of high-quality products at an affordable price; a public awareness of the need for and availability of coverage through the Marketplace; and the ease of the registration, shopping, and enrollment processes. To this end, the State has established a comprehensive consumer engagement program, including navigators and a broad-based marketing campaign, to encourage adoption. The State will continue to monitor insurance uptake and adapt and refine the consumer engagement effort as required to meet our target levels of adoption.

1.2 STRENGTHEN OUR SAFETY-NET PROVIDERS WHO SERVE NEW YORK'S MOST VULNERABLE POPULATIONS

The citizens of New York State are served by a broad range of both nonprofit and publicly funded providers whose mission is to deliver health care to all, regardless of a person's ability to pay. These "safety-net providers" play the critical role of ensuring access to care for our population's most vulnerable members who cannot afford or cannot otherwise obtain health care insurance. Many of these health care providers face an ongoing challenge with financial sustainability. In addition, demand for safety-net services, community health centers, and federally qualified health centers sometimes exceeds the supply of these providers, leading to excessively long wait times for an appointment.

The State is committed to supporting safety-net providers, particularly those who demonstrate the capability and intention of achieving the highest levels of quality and safety performance at the highest levels of operational efficiency and cost-effectiveness. To this end, more than $2 billion of funding, linked to the pending MRT 1115 waiver, is targeted for investment in these safety-net providers. This effort, known as the Delivery System Reform Incentive Programs (DSRIP), represents a pivotal part of the State's effort to provide timely access to quality care for all New Yorkers. To ensure that these funds achieve the maximum possible return on investment (ROI), they will be linked to the providers' efforts to build capabilities that promote their long-term high performance and financial sustainability. Importantly, for relevant providers, funding will be linked to activities that are aligned with other elements of the State Health Innovation Plan, such as the implementation of Advanced Primary Care (APC), value-based payment models, and strong linkages to community support for prevention and screening.

1.3 INCREASE WORKFORCE CAPACITY IN UNDERSERVED REGIONS

Although New York has more health care workers per capita than most other states, there is a high level of regional variation. Parts of 50 of 62 counties in New

York State are considered "underserved" from a health care workforce perspective, with significant implications for the ability of residents to get timely access to care, regardless of their insurance status.[62] Accordingly, the State is committed to supporting both the targeted growth and redistribution of the health care workforce, to ensure that New Yorkers in all regions of the state have timely access to quality health care. The comprehensive set of initiatives we are supporting in this area is further detailed in the "Workforce Development" section of this document, and include:

- **Capacity-focused initiatives**, including exploring expanded clinical education admission criteria that increase student exposure to rural and non-hospital settings; testing approaches to increase in-state retention of new physicians who complete training in New York; and increasing the attractiveness of primary care careers in underserved areas
- **Capability-focused initiatives**, including developing competencies in not only patient care but also in business management and IT
- **Workforce flexibility-focused initiatives**, including increasing role flexibility and scope overlap in relation to primary care services and increasing geographical flexibility through telehealth
- **Workforce planning**, including improving the effectiveness of the Health Workforce Data Repository, increasing New York's capacity to test and evaluate models of care, and identifying and addressing the implications of major structural changes

1.4 MAKE CARE MORE ACCESSIBLE, THROUGH EXTENDED HOURS, SAME DAY APPOINTMENTS, AND USE OF TECHNOLOGY

While broad insurance coverage, strong safety-net capacity, and equitable geographic distribution of the workforce are important components of improving access, they are not of themselves sufficient. We aspire to much higher access goals. We believe that timely access to care means being able to secure high quality primary care at the time of need (in the case of urgent care requirements), or at a time and location that is truly convenient (in the case of non-urgent and preventive care) and accessible. For example, persons with disabilities must be afforded access to care through removal or architectural barriers, provider training on disability literate care. Our work must consider the needs of all New Yorkers, particularly those who suffer disparate access to care and treatment.

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62 Health Resources and Services Administration, "Health Professional Shortage Areas." <http://hpsafind.hrsa.gov/HPSASearch.aspx> Accessed 18 October 2013.

Achieving this requires that we move beyond a model of care that is largely based on weekday office hours and tied to the physical location of clinician. Rather, we envision an end-state where primary care is far more accessible outside of standard hours (e.g. on evenings and at weekends), and at short notice (e.g. through same-day appointments) and where widely used technologies such as video, telehealth, online, and phone-based consultations allow New Yorkers to access care conveniently, at low cost, without sacrificing quality.

Under the State Health Innovation Plan, we will lead the State toward this ambitious end-state through four important levers:

- Including targets for same-day access and extended hours as part of our APC recognition criteria, building on current NCQA requirements (further defined in Pillar 2 of the Plan);
- Assisting providers to deliver services in an efficient, cost-effective way, by incorporating targeted training in both Practice Transformation and Care Coordination training curriculums (further defined in Enabler A of the Plan);
- Continuing to act as a conduit for the transfer of ideas and best practices relating to telehealth and other technologies that improve access to primary care (further defined in Enabler B of the Plan);
- Developing a more sophisticated measure of 'access' that goes beyond coverage and capacity and reflects both the timeliness and convenience of care options that are available and build the State's ability to track performance against these measures. We anticipate this advanced level of transparency could play a key role in engaging consumers and encourage them to seek out providers who deliver the type of access that best suits their needs. Providers will thereby have both incentives and rewards to lead the way in transforming access across our state.

2. Provide Integrated Care for All

Our current health care system is highly fragmented, with consumers struggling to independently navigate a complex array of providers who frequently operate in isolation from one another without shared health information or open lines of communication.

In our future State health system, care will be integrated around patients' needs. Patient, provider and payer engagement will be key to the long-term success of the plan, and all will be key partners in overall system design and regional planning. Our strategy for promoting integrated care is outlined in the following pages and organized in five parts:

1. **Establish Advanced Primary Care (APC) as a universal model for statewide, multi-payer adoption**
2. **Promote consistent standards and expectations for APC capability on a spectrum of advancement to achieve fully integrated care**
3. **Adopt a regional approach to system transformation including practice transformation support, leveraging reliable and tested technical assistance approaches**
4. **Deploy an APC recognition process that builds on NCQA standards or equivalent standards such as CPCi criteria**
5. **Continue to support and assure integration with complementary care delivery models for special or high needs populations such as health homes and behavioral health organizations**
6. **Encourage the development of integrated service and payment models including but not limited to Accountable Care Organizations.**

2.1 ESTABLISH APC AS A UNIVERSAL MODEL FOR STATEWIDE, MULTI-PAYER ADOPTION

The heart of New York's State Health Innovation Plan is a new, statewide approach to support the transformation of primary care from reactive management of discrete encounters to proactive management of a population's needs, including prevention, chronic disease management, and coordination of care with all providers: primary, specialty, acute, and long-term. The proposed care delivery model is a population health management model, grounded in foundational medical home precepts, with primary care physicians (PCPs) supported and accountable for integrating care needs across their patient panel to optimize health, health care outcomes, and total cost of care. We are confident that this model of primary care – the APC -- is fundamental to success in tackling New York's health

care delivery challenges: a rapidly growing prevalence of chronic diseases; suboptimal management of complex and chronically ill populations; excessive inpatient admissions; and high unit costs.

Models that strengthen primary care have shown a compelling return on investment in many studies across more than 30 states. Although a range of impacts have been observed, the most successful medical home models show emergency department visits and inpatient hospitalization reduced by up to 50 percent,[63] contributing to total cost of care savings of up to 20 percent.[64]

In addition to financial savings, medical home models frequently show improvements in the quality of care, patients' experiences, access, and clinical outcomes.[65,66] A key factor to achieve these non-financial benefits is creating a personal care relationship between the health care consumer and provider. Although 93 percent of Americans want one place or doctor who provides and coordinates care,[67] shown to be critical to achieving positive health outcomes,[68] only a minority of New Yorkers currently have such an experience. Investments in strengthening primary care have also shown benefits in several NYS programs. The Medicare Advanced Primary Care Practice initiative (MAPCP, also called Adirondack Medical Home program) has reduced Medicaid patients' risk-adjusted per-patient-per-month (PMPM) health care costs by 20 percent from 2009 figures while improving health and access.[69] Similarly, a Capital District Physicians' Health Plan (CDPHP) pilot has shown on average $8 risk-adjusted PMPM savings

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63 Grumbach K., Bodenheimer T. and Grundy P. The Outcomes of Implementing Patient-centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies. Patient-Centered Primary Care Collaborative; August 2009.

64 Examples include Colorado Children's Healthcare Access Program (CHAP) and Florida Capital Health Plan.

65 Grumbach K., Bodenheimer T. and Grundy P. The Outcomes of Implementing Patient-centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies. Patient-Centered Primary Care Collaborative; August 2009.

66 Rosenthal et al. Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. *JAMA Intern Med.* Published online September 9, 2013.

67 AHRQ publication No. 12-0020-EF: Early Evidence on the Patient-Centered Medical Home. February 2012.

68 The patient centered medical home: history, seven core features, evidence and transformational change. Robert Graham Center for Policy Studies in Family Medicine and Primary Care. November 2007.

69 From $334 in 2009 to $266 in 2012. Source: Treo Solutions; Advisory Board interviews and analysis; Post-start article "'Medical home program' gains traction" on October 6.

by reducing hospital admissions, emergency department visits, and advanced imaging.[70]

However, the evidence supporting the return on investment for medical home models is not uniformly positive, with other programs and academic articles suggesting only moderate or even negative impact on cost and quality.[71] These differences reflect the fact that each medical home model is unique, evaluation methods vary, and frontline implementation requires complex change that takes time and capabilities. Despite the mixed empirical evidence, there is a strong, emerging consensus that integrated models of primary care, correctly implemented, are an essential backbone to an effective health care delivery system.

2.1.1 Care delivery design principles

The design of the care delivery model proposed in the Plan has been shaped by five key design principles:

- **Fit with existing priorities and innovations.** *The care model must seamlessly build on and integrate with existing priorities and innovations across the State.* This design principle is first reflected in the relationship that has been defined between the Plan, the pending MRT 1115 waiver, and the NYS Prevention Agenda 2013–2017. It is also demonstrated by how the new model will interface with the National Committee for Quality Assurance (NCQA) and the Comprehensive Primary Care Initiative (CPCi) provider participation standards. It is further shown in the way the Plan will enable continued growth and innovation across the State's existing primary care programs, for example, MAPCP, Montefiore Pioneer Accountable Care Organization (ACO), the Healthcare Innovation Grant for Finger Lakes Health System, and the Capital District-Hudson Valley CPCi.
- **Degree of standardization.** *Standardization should be required only where necessary to allow interoperability or to capture scale benefit. The level of standardization should reflect only that which is required to achieve those goals, or to promote effective alignment of practice improvement efforts across payers or initiatives. The care delivery model should encourage innovation and entrepreneurship across payers, providers, purchasers, and locations*. This design principle has informed the decision to let detailed

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[70] NYS Health Foundation website on October 8: CDPHP presentation on Comprehensive Payment for Comprehensive Care from November 14, 2012; calculation by University of Massachusetts Medical School and Boston University.

[71] AHRQ publication No. 12-0020-EF: Early Evidence on the Patient-Centered Medical Home. February 2012.

models of care coordination and practice transformation be determined by individual sets of stakeholders, or be aligned at a regional or local level. By contrast, areas where the Plan does strive for standardization include the definition of key metrics and standard reporting, standards for HIT interoperability, and the overarching process that will articulate practice standards for participation.

- **Importance of support for practice transformation and care coordination.** *The Triple Aim cannot be achieved unless practice management and care coordination are truly transformed, so that PCPs have the capabilities required to care for the total needs of a panel of patients. This change in focus takes time and substantial financial resources—and not all practices will make the transition.* This design principle is reflected in the staged definition of the new model of APC, which is designed to help differentiate the level and nature of support that different practices will need to succeed. It is further reflected in the incentives created for payers to invest in practice transformation and care coordination, which aim to minimize the "free rider" challenge often associated with investment in health care transformation. It also encourages payers to prioritize their investments in practices that have a strong probability of making the transition and becoming effective managers of population health.
- **Role of transparency and data sharing.** *Fully optimized population health management is only possible when primary care providers have access to data about their patients, enabling them to make use of quality outcomes, utilization, and cost performance results across the health care delivery system that their patients use*. This design principle is reflected in the high priority the Plan places on the supporting HIT strategy, and the leadership role that the State is taking in bringing both the All-Payer Database (APD) and the SHIN-NY rapidly into fruition.
- **Role of recognition, measurement, and evaluation.** *The standards and specific evaluation measures used to define what constitutes "Advanced Primary Care" need to be consistent across payers, and together need to focus on the right mix of structure, process and outcomes.* This principle is reflected in the Plan's commitment to defining a common set of measures for evaluating practice and provider performance, to minimize complexity for providers, and to ensure interoperability of data flows and reporting mechanisms. The aim of this performance evaluation is to shift from sole focus on volume-only definitions of productivity to greater inclusiveness of clinical outcomes. It is also reflected in the Plan's intent to align processes and to demonstrate real practice capabilities and behaviors required at each APC level.

- **Accountability**. Although all practices will have the opportunity to undergo the same performance measurements and receive the same reporting from the APC Performance Tool, the measures for which they are held accountable and the performance thresholds will vary depending on the stage of APC. This design permits broad participation of practices but encourages practices to move along the spectrum of transformation. Accountability will be assured through measurement of practice and provider performance.

2.2 PROMOTE CONSISTENT STANDARDS AND EXPECTATIONS FOR APC CAPABILITY BUILDING, ON A GRADUATED PATH

Acknowledging that different provider practices have different structural and financial capabilities, the model defines three stages of APC, aimed at three different segments of the provider market. At each stage, the aim is to optimize the effectiveness of population health management, within the limits of the segments' capabilities. Exhibit 14 below provides an aggregate overview of the APC stages. It should be noted that although practice size is not expected to determine where a practice sits on the APC spectrum, it is anticipated that smaller practices may find it more difficult to progress to the far right of the spectrum than medium and larger practices. To this end, some smaller practices may wish to implement key components of the model, not all, and may wish to explore forms of aggregation and collaboration that help them capture the benefits of scale while maintaining elements of independence. The State will look to support and facilitate such efforts, in line with the aspirations defined below for the APC model.

EXHIBIT 14: APC STAGES OF TRANSFORMATION

APC Stages of Transformation

Tier	Pre-APC	▶ Standard APC	▶ Premium APC
Description	• Largely reactive approach to patient encounters of care	• Capabilities in place to more proactively manage a population of patients	• Processes in place to clinically integrate primary, behavioral, acute, post-acute care[1]
Capabilities required to enter tier	• Limited pre-requisites • Willingness to exchange targeted clinical data	• Certified EHR • Full medical home capabilities, aligned with NCQA Level 1-3, or equivalent	• Certified EHR, Meaningful Use Stage 1-3[3], HIE interoperability • Enhanced capabilities, aligned with expanded NCQA Level 3[2], or equivalent
Validation	None	• Required to maintain care coordination fees >12 months • To couple with practice transformation support	
Care coordination skills	• Limited or none	• Care planning for 5-15% highest-risk patients • Track and follow up on ADT, other scalable data streams • Facilitate referrals to high-value providers	• Plus, functional care agreements in medical neighborhood • Plus, community-facing care coordination
Payment model mix	• FFS + P4P • Potential EHR support	• Shared savings or capitation • Care coordination fees • Transformation support	• Shared savings or capitation
Metrics and reporting	• Standard statewide scorecard of core measures • Consolidated reporting across payers, leveraging APD, portal		

1 Vision, LTC, home aids, rehabilitative & daycare are excluded from all advanced primary care models
2 Establishes additional must-pass NCQA requirements that are not already mandatory in existing NCQA
3 Once available

- **Pre-APC**. Most primary care providers are currently at the stage, which is likely to be of most relevance to smaller-scale practices that have demonstrated emerging interest in playing a proactive role in managing the health of their patient panel and having some basic care coordination capabilities in place. Although these practices may not have the scale, capabilities, or infrastructure to fully manage their population's health, it is anticipated that the effectiveness of these practices could be optimized by a payment mechanism that rewards specific outcomes and practices rather than a pure fee-for-service (FFS) payment model. It is anticipated that the minimum practice performance requirements for this stage would reflect selected NCQA "must-pass" sub-elements related to panel health management and enhanced access to care.
- **Standard APC**. This stage will be most relevant for small to medium-scale practices that have the interest and potential capability required for comprehensive care management and coordination of all but the most complex of their patient panel's needs. While these practices may lack the financial capital and management expertise to take on the most complex

financial arrangements, their effectiveness could be optimized through practice transformation support and a payment mechanism that allows them to participate in the financial benefits created by high-quality care integration. It is anticipated that the minimum requirements for designation as a Standard APC practice would reflect current NCQA standards, together with mandatory use of a certified EHR system, or potentially could reflect eligibility criteria used by CPCi.

- **Enhanced APC**. The third, most integrated, stage of the APC transformation journey is a truly comprehensive population health management model. This currently represents the smallest number of practices in the State. In this stage, primary care physicians take responsibility for coordinating the complete health and social care needs of any given patient (acute physical, long-term, and behavioral health care). Once the relevant tools are fully functional, these practices would be optimizing the data available on the SHIN-NY and the APD (or using equivalent internal capabilities) to fully understand quality, utilization, and cost variations across referral networks. Enhanced APC practices would also leverage data available from statewide data portals and from payers to risk-segment patient panels in order to provide the highest quality, most effective, and most comprehensively integrated care possible. It is anticipated that practices implementing enhanced APC will have both the financial resources and management capabilities to engage in more sophisticated or innovative payment models than other providers. Standards for this stage will most likely require validation of capabilities that exceed traditional medical home standards, including effective implementation of selected Prevention Agenda priorities, advanced HIT usage, and adoption of the Collaborative Care model to include behavioral health integration.

It is anticipated that the threshold between pre-APC and standard-APC practices will need to be clearly articulated as this defines the transition point at which practices become entitled to Practice Transformation funding, as well as access to Care Coordination payments (outlined in further detail below). However, the transition between standard and enhanced APC is likely to be on a more continuous spectrum – both in relation to population health management capabilities, and the appetite and ability to take on financial risk for total cost of care management.

As described in the paragraphs above, the Plan focuses on PCPs as key change agents for the health care delivery system. However, other health care providers, including specialists, will also be impacted by the Plan. The most direct changes will come from increased pressure to become involved in a ‘medical neighborhood’, with greater sharing of clinical information, and greater transparency over cost and quality outcomes, driven by the more proactive role

that PCPs will play in managing health care value across their patient panels. Over time, the scope of the Plan could broaden further to include specific evolutions to the delivery model for specialists or in the acute care setting (e.g. adopting an 'episodes of care' approach to care delivery and payment for specific, high volume specialist procedures). We look forward to continuing to explore these opportunities together with our stakeholders, but in the near term remain closely focused on embedding the APC model as the starting point and heart of our delivery system transformation.

2.2.1 Care coordination

A crucial component of population health management models is care coordination. Care coordination is a model of patient/family-centric team-based care management. The objective is better health of individuals and more effective utilization of resources that meet a patient's medical, functional, and social needs through the following key activities:

- **Individualized care plans** developed and kept up-to-date in collaboration with the patient/family, to facilitate proactive rather than reactive healthcare
- **Self-management support** and follow-up to improve health outcomes and reduce the overall disease burden on health system
- **Population health management and patient panel segmentation** to identify high-risk, high-cost patients for more intense care coordination and to drive proactive preventive care efforts for low-risk patients in an effort to manage future health care costs
- **Evidence-based medication management and referral** to clinical and social supports to improve safety, effectiveness, and compliance with respect to medication use, especially during care transitions.

A wide range of care coordination models currently exists across the State. During the initial implementation phase, groups and entities already working on these initiatives will be asked to share best practices and offer insights. For example, the Primary Care Information Project (PCIP) of the New York City Department of Health and Mental Hygiene is implementing the "Interconnectivity Initiative" to provide physician practices with greater connectivity to other hospitals and practices. This initiative will inform best next steps to assure statewide coordination and communication where possible.

It is clear that there is not a single 'best practice' approach to how care coordination is structured, funded, or delivered, particularly taking into account the heterogeneity of practice types and panel demographics. Models tend to vary across five key dimensions:

- Patient focus: this can range from a whole-panel methodology to a care coordination focus on only the most complex patients
- Role definition: coordination activities can be performed by one assigned care coordination person in a practice, be shared among different staff within one practice, or be shared between practices and even between payers
- Role funding: care coordination services can be funded through either a "build or buy" approach. In particular, small practices may opt to hire or buy professional, part-time care coordination services that are shared with other small practices
- Role location: the location of care coordination activities may be patient-based, practice-based, community-based, or remote office-based. For example, a commercially insured child with a developmental disability may need a patient-centric care coordinator, who can help the child navigate through different care settings, such as the pediatrician, specialists, community programs, and special educational facilities
- Enabling tools: care coordination models are enabled by a range of supporting tools such as payer software for population risk stratification, remote health monitoring devices, patient outreach protocols, and HIT for utilization and performance tracking of clinical and non-clinical (community) services. The nature of these tools can have a substantial impact on the appropriateness of each of the design dimensions described above

In an effort to build alignment across NYS care coordination activities, the State will encourage implementation of an aligned, multi-payer model. This alignment will be based on articulated quality and capacity principles of good care management to be agreed upon between payers and providers. In an effort to build clear accountability across the system, the State will also encourage payers to agree on the boundaries of APC-driven care coordination in the primary care setting versus more advanced forms of care coordination seen as part of nursing homes, health homes, or the FIDA demonstration program. Additionally, the State aims to increase transparency over care coordination-related metrics on the standardized scorecard (see the "Performance Measurement and Evaluation" section), as well as financial or operational support provided from payers to providers for care coordination activities. Because of the importance of multi-payer alignment on this issue, it is intended that the approach to care coordination be a key focus area for the detailed design phase of Plan implementation. We look forward to working closely with payers and providers to determine the most effective path forward.

2.2.2 Behavioral health integration

Enhanced APC providers will be urged and supported to integrate behavioral health in their standard primary care practices. Behavioral health integration will

be supported and promoted through statewide rollout of the Collaborative Care approach in Enhanced APC practices.

The Collaborative Care approach aims to detect and manage common mental health conditions in primary care settings, with an initial focus on depression. This approach is widely recognized as best practice, including by the Substance Abuse and Mental Health Services Administration (SAMHSA). It has demonstrated improved outcomes for mental health and other chronic health conditions such as diabetes, hypertension, and high cholesterol. Savings, over time, principally accrue in reduced high intensity medical services, including ED and inpatient medical care (i.e., not mental health services).

APC practices also identify and respond to the needs of patients who use alcohol and other drugs at risky levels, and engage in behavior associated with health consequences, disease, accident, and injury. They will use techniques like Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based approach that focuses on brief interventions through discussions focusing on health and other consequences.

This fully integrated, screening and primary care management approach includes:

- Training primary care providers in screening for, monitoring, and treating depression using one standardized measurement tool (PHQ-9)
- Employing managers in the primary care setting care who engage and educate patients as well as provide basic counseling and medication support for the treatments initiated by a primary care doctor
- Creating linkages with psychiatrists who consult with primary care physicians and care managers on those patients who do not respond to treatment—as identified by tracking the progress of depressed patients using a behavioral health registry
- Activating patients to manage their own health and wellness

2.2.3 Preventive care integration

In contrast to the highly specific Collaborative Care approach outlined above, integration of NYS Prevention Agenda 2013-2017 priorities spans a wide range of activities to improve screening and diagnosis across multiple clinical conditions and disease areas. In particular, Enhanced APC providers will be better able to care for their patient panel proactively through enhanced HIE, regional planning and creation of detailed community resource guides.

Specifically, APC providers will be encouraged, programmatically and fiscally to be accountable for the following Prevention Agenda objectives, in addition to any objectives identified through county-level Prevention Agenda plans:

- Providing and coordinating age and developmentally appropriate child care, including vaccinations, developmental screening, and preventive oral health practices, for all children, in accordance with AAP/Bright Futures guidelines
- Integrating routine preconception and interconception care in routine primary care delivered to women of reproductive age (including screening and follow up for risk factors, management of chronic medical conditions, and use of contraception to plan pregnancies)
- Offering systematic screening and disease management for diabetes, obesity, hypertension, tobacco use, colorectal cancer, and asthma, in accordance with the NYS Prevention Agenda 2013–2017 guidelines and the evaluation metrics included in the standard APC evaluation scorecard (see the "Performance Measurement and Evaluation" section).

Additionally, initiatives to strengthen clinical-community linkages (discussed in the "Connect Primary Care to Population Health Improvement" section) and improve linkages between primary care practices and specialists will encourage PCPs to play a more accountable and dedicated role in population health improvement.

2.3 DEPLOY AN APC RECOGNITION PROCESS THAT BUILDS ON NCQA

All NYS licensed providers are eligible to implement APC. The Plan seeks to assure that at least 80 percent of the NYS population be in the care of an APC provider by 2018, independent of health or socioeconomic status.

To facilitate this process, we anticipate it will be helpful to establish an effective but streamlined process for APC recognition. For patients, practices with APC status (together with performance metrics) will serve as a marker of high-quality, holistic primary care. For payers, these standards can act as a marker of which practices have the structural readiness and willingness to pursue a specific stage of APC transformation, and as such are likely to have the capacity to succeed with higher risk-sharing payment arrangements (see the "Pay for Value not Volume" section). For providers, APC recognition provides an acknowledgement of a practice's ability to provide higher levels of coordinated patient care, and should provide the basis for negotiating enhanced income, linked to the delivery of enhanced care and care outcomes.

This section proposes a draft approach to APC standardization, which will be developed further in collaboration with relevant NYS stakeholders (see the "Transformation Roadmap" section). There are four principle elements to the proposed approach:

- **Alignment with NCQA processes:** NYS has relatively high adoption of NCQA recognition (~25 percent), and the NCQA infrastructure provides a

strong foundation for the APC recognition process. We will seek to work closely with NCQA to define a path forward under which NCQA processes could form the foundation of how practices achieve APC recognition.

- **Augmentation of NCQA standards:** We have consistently heard from key stakeholders that there is a need to ensure that NCQA standards are met every day, not just during the timeframe in which practices are submitting documentation for recognition. The APC model is consistent with principles embedded in NCQA PCMH criteria; however, we want to move beyond just structural criteria by seeking durable meaningful changes in processes and outcomes. We intend to work collaboratively with NCQA and local stakeholders to help shape this 'augmented' approach, which we believe can be achieved largely within the existing infrastructure (see the "Provide Integrated Care for All" section)
- **Recognition process that evolves to reflect practice readiness:** In acknowledgement of the spectrum of alternative PCMH-related recognition processes that exist in NYS, practices will be given the opportunity to demonstrate structural readiness to pursue a specific stage of APC through any PCMH-equivalent recognition process (for example, achieving all CPCi criteria). All practices, regardless of 'entrance' criteria, will need to show evidence of effort and success at improvement through performance metrics to remain in alternate payment programs.
- **Synchronization with the APC scorecard**: recognition is only the 'front end' of the process of identifying and rewarding high performing APC practices. It indicates 'structural readiness' to operate as an APC, rather than demonstrated capability. Stakeholders have noted that recognition processes also come with inherent validation challenges and an imperfect level of emphasis on structure and processes rather than capabilities and outcomes. Accordingly, we intend for existing recognition programs to be used in close conjunction with the APC scorecard that is defined in the "Performance Measurement and Evaluation" section of this document. This scorecard will provide rigorous insights on practice quality, utilization and cost outcomes, which will form an important component of ongoing assurance of primary care quality over time.

2.3.1 APC eligibility criteria

Given that current recognition processes and eligibility criteria vary widely between payers and specific innovation programs, the State will work across stakeholders in the provider and payer community to facilitate alignment on standard principles for APC eligibility.

The section below sets out our initial working draft of recognition criteria, for discussion and finalization in collaboration with our key stakeholders:

- To demonstrate readiness for **pre-APC** implementation, practices would be expected to demonstrate that specific structures or processes have been established to achieve the following:
  - reduce unnecessary emergency department, hospital, or specialist visits by offering consultations for patients needing care (advice) both during and out-of-office hours
  - reduce potentially preventable adverse outcomes by proactively performing health assessments and generating care plans that promote active care management and self-care, particularly for patients with chronic disease at high risk of decompensation
  - track and improve practice performance with the aim of achieving standard APC criteria as soon as possible

  Within the NCQA-recognition methodology, specific pre-APC criteria could, for example, involve mandatory passing of five PCMH "must-pass" sub-elements: same-day appointments, individualized care plans, self-management plans, referral communication, and goals and actions to improve performance.[72]
- Practices interested in implementing **standard APC** must have a certified EHR system[73] and demonstrate specific structures or processes have been established to achieve the following:
  - provide access to routine care and urgent team-based care that meets the needs of the patient panel
  - systematically record patient information in an EHR and use it for population management to support patient care
  - systematically identify individual patients and plans, in particular high-risk high-cost patients, and manage and coordinate their care based on their condition, individual needs, and evidence-based guidelines
  - improve patients' ability to manage their health by providing a self-care plan, tools, educational resources, and ongoing support

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[72] Hereby recognition would not be purely based on the overall PCMH score, but also on scores for individual sub-elements—requiring NCQA to gain permission from providers to share these with the APC recognition entity, and potentially even publicize them for the purpose of improved transparency.

[73] As specified by Meaningful Use and PCMH standards: Uses EHR system (or modules) that has been certified and issued a Certified HIT Products List (CHPL) Number(s) under the Office of the National Coordinator for Health Information Technology (ONC) HIT certification program.

- systematically track test results and coordinate care across specialty care, facility-based care, and community organizations
- use performance data to identify opportunities for improvement and to actually improve clinical quality, efficiency, and patient experience
- reduce the total cost of care by proactively identifying and referring to specialists, hospitals, and community resources that demonstrate cost-efficiency as well as high quality outcomes

Within the context of the NCQA-recognition methodology, these medical home capabilities align with achieving at least Level 1, and ideally Level 3 PCMH recognition (2011/2014). Alternatively, use of other equivalent approaches, such as CPCi eligibility criteria, may be considered.

- Eligibility criteria for **enhanced APC** practices should be more stringent than existing medical home recognition standards in order to earmark providers who are truly ready to be both operationally and financially accountable for the total care of a patient panel and, to some extent, the surrounding medical community (see the "Provide Integrated Care for All" section). Such practices would be expected to meet Meaningful Use, Interoperability, and HIE integration standards[74] as well as have structures or processes in place:
  - to perform team-based care
  - to record, track, and report clinical data
  - to integrate behavioral health and preventive care into primary care
  - to proactively perform comprehensive health assessments on patient groups identified through population health informatics
  - to coordinate and provide care for individuals identified as high risk
  - to effectively collaborate with the local community to improve patient outcomes and overall population health
  - to actively manage and follow up short-term care transitions (for example, to specialist referrals), and long-term or permanent care transitions (into nursing homes, for example) and participate in medication reconciliation activities.
- Within the NCQA-recognition methodology, this implementation could, for example, involve Level 3 recognition, with the addition of seven PCMH "must-pass" elements for practices aiming at enhanced APC status: the practice team (with mention of remote psychiatrist availability),

[74] As per most recent standards available at the time of recognition, discussed further in the "Health Information Technology" section.

comprehensive health assessment, implementation of evidence-based guidelines (with mention of the Collaborative Care approach, Bright Futures guidelines, and pre-specified Preventive Care protocols), identification of high-risk patients, provision of referrals to community resources, and coordination with facilities and manage care transitions.

2.4 ADOPT A REGIONAL APPROACH TO PRACTICE TRANSFORMATION

An important enabler of the APC delivery model is practice transformation support. Practice transformation support is a practice-centric service provided by a trained individual or team of individuals, typically for a predetermined amount of time, to help primary care practices transition to APC. Evidence suggests that such support can increase the chances of successful transformation by up to fivefold.[75]

Key practice transformation activities include:

- **Organizational development** to prepare practices to assume new fiscal, administrative, and leadership responsibilities required to manage overall APC processes, change program milestones, and transition to value-based payment arrangements
- **Clinical process design support** using IT tools to enable development of dynamic care plans, follow-up on patient care needs, and integration of behavioral health and preventive care in the PCP practice
- C**ommunication networks installation** to facilitate team-based care within the practice and continuous information exchange with the referral network and community, including connection to the HIE and implementation of selected Meaningful Use guidelines.
- **Quality and practice improvement approaches** through new practice management software and meaningful use of EHR to help practices engage in improvement activities over time and support them in reaching incremental and transformative improvement goals

In addition to the above activities, a wide range of other initiatives need to be tailored to practice-specific needs and goals, commonly identified by practice

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[75] A study conducted by health insurer EmblemHealth of New York practices with fewer than 10 physicians showed that 95 percent of intervention practices (which received 18 months of practice redesign support, two years of redesigned payment, and 18 months of embedded care management supports) received NCQA PCMH recognition in 18 months, compared with 21 percent of controls. Also, a meta-analysis by Baskerville, Hogg and Liddy from 2011 of studies on practice transformation within primary care settings concluded that primary care practices are almost three times as likely to adopt evidence-based guidelines through practice transformation support compared with no-intervention control group practices. The study found that impact was correlated with the number and length of facilitation sessions. Source: Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide, AHRQ Publication No. 12-0011, December 2011.

readiness assessments. For example, large care organizations, such as ACOs, may need assistance in developing more advanced employee-contracting capabilities. These capabilities will be necessary to translate value-based financial incentives at the practice level to value awareness among employed physicians, which constitute an increasingly high proportion of NYS PCPs.

To ensure that practice transformation investments deliver a positive ROI, it is expected that practices will need to reach a certain minimum threshold of APC capability before qualifying for support – as a way of demonstrating their willingness and interest in truly transforming. This minimum threshold will be defined as the transition point between the 'pre-APC' and 'standard-APC' stages of transformation.

In a further effort to ensure that investment in transformation support is as effective and efficient as possible, the State aims to encourage and promote participation and alignment by all payers so that any given practice is able to adopt a single, practice-wide approach to transformation.

Finally, it is anticipated that regional organizations will play an important role in supporting practice transformation. In the current stage of model design, we are considering an approach to practice transformation that describes core categories of assistance and potentially structures contracts on a regional basis. We envision that regional governing entities will provide input into practice transformation vendor selection aligned with overarching statewide standards and metrics. We are in the process of refining this approach, which will aim to strike the right balance between leveraging regional strengths with the provision of State-level guidance and minimum standard setting. Working together with payers and providers, the State intends to support a collaborative approach during the 'detailed design' phase of Plan implementation to agree on the following:

- Level of standardization that should be adopted in models of practice transformation
- Triggers for eligibility for practice transformation funds, and how transformation should be funded
- The role that the State or other governing body should play in pre-qualifying practice transformation vendors and in developing transformation tools and resources

From the provider point of view, primary care practices will now have greater rationale and support to participate in care delivery transformation due to a stronger underlying business case. The business case is buttressed by practice transformation support and value-based payment models that are potentially comprised of care coordination payments and gain-sharing incentives. (Payment alignment is further discussed in the "Pay for Value not Volume" section.) With

multi-payer participation, providers can benefit from greater consistency in the market's approach to integrated care, technical assistance to achieve it, and common expectations for structural, process, and outcome achievements.

Transparency initiatives (discussed in the "Increase Transparency to Empower Consumers, Payers, and Providers" section) will give providers greater insight into care features, including quality, within their referral networks. Regional organizations can provide further, locally-tailored assistance that is reflective of unique regional characteristics such as a preponderance of hospital-sponsored primary care such as is the case in much of downstate New York. Last, providers will have an opportunity to enact fundamental operational and organizational change within their practices, and to do so with the support from payers and the State. We anticipate that the overall shift toward greater support for integrated care will catalyze providers' preparations and investments in their practice models, resulting in more providers adopting progressive stages of APC.

From the payer point of view, payers participating in the general APC model will be helping to create statewide momentum and scale that will drive provider participation. At the same time, flexibility in the APC model will allow payers to maintain the ability to differentiate competitively. Payer support to enable providers to effectively implement the APC model will drive the business case for reduced costs while improving care quality and health outcomes. Ultimately statewide infrastructure supports such as the APD and SHIN-NY will be available to all payers. Regulatory processes (for instance, Form and Rate Review as discussed in the "Pay for Value not Volume" section) will recognize payers' efforts to innovate and increase value-based approaches across providers. Lastly, payers will be asked to collaborate closely with the providers and the local community to ensure that regional approaches for technical support and implementation are as effective and aligned as closely as possible.

We recognize that further work will need to be done in the coming months on technical design and operational issues, including finalizing thresholds for moving between stages, requirements for practices to maintain APC status over time, detailed funding processes and mechanics for practice transformation and care coordination, and mechanisms for supporting collaboration among providers.

2.5 CONTINUE TO SUPPORT COMPLEMENTARY CARE DELIVERY MODELS FOR SPECIAL NEEDS POPULATIONS

The new NYS care delivery model builds on the blueprint outlined in the pending MRT 1115 waiver—New York's DSRIP plan is focused on reducing avoidable hospital use. While there are multiple avoidable hospital use measures, New York proposes to build on existing performance metrics used in its Medicaid managed

care program. Specifically, New York proposes to the use the four following nationally-recognized measures for avoidable hospital use:

- Potentially Preventable Emergency Room Visits (PPVs): a set of measures that identify emergency room visits that could have been avoided with adequate ambulatory care
- Potentially Preventable Readmissions (PPRs): a set of measures for readmissions to a hospital that follows a prior discharge from a hospital and that is clinically-related to the prior hospital admission
- Prevention Quality Indicators – Adult (PQIs): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs are population-based and can be adjusted for covariates for comparison purposes.
- Prevention Quality Indicators – Pediatric (PDIs): a set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the health care system and that may be amenable to prevention by changes at the system or provider level. Similarly the PDIs are population based and can be also be adjusted for covariates for evaluation.

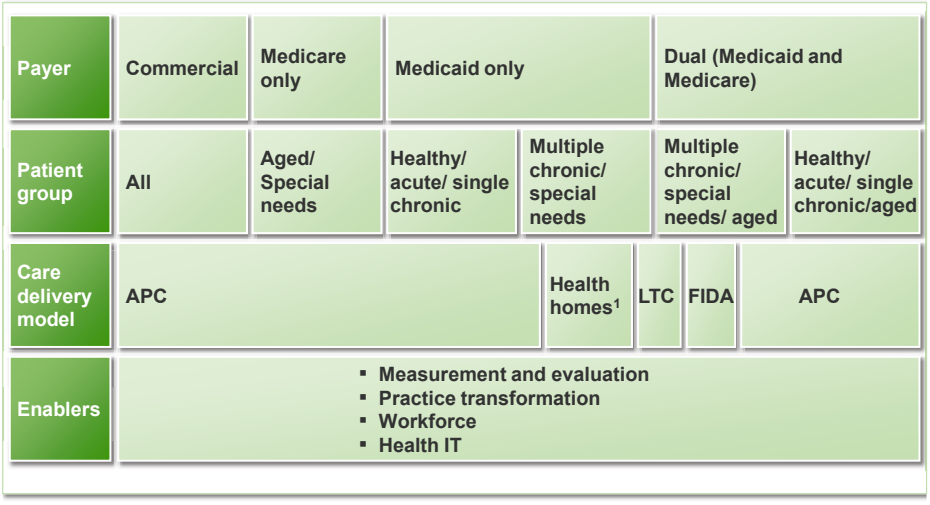
In sum, these measures reflect a comprehensive view of avoidable hospital use. The baseline for evaluation will be actual 2011 Medicaid results. Performance will focus on all Medicaid members, including the dually-eligible population, which meet the criteria for inclusion for each measure. The five-year goal is to reduce each measure by 25%. The state expects to be at least 50% of the way to the 25% reduction mark by the waiver's third year to ensure integrated, value-based care for all Medicaid recipients—and creates the mechanisms and incentives for extending this model across the commercial market. It also provides a practical vehicle for putting into operation key aspects of the State's Prevention Agenda and scaling up the Collaborative Care approach by promoting fully integrated systems. In addition, this model has been designed to reflect and leverage the experience of major primary care innovation models that have been developed across the State in the last five years. The Plan will build on and reinforce these existing and emerging programs, ensure alignment with the proposed primary care model, and promote continued expansion to meet identified objectives.

NYS' most vulnerable populations require integrated care that goes beyond primary care innovation models. Specifically, persons with serious mental illness and/or substance abuse disorders often receive care in specialized behavioral health settings. But many do not access routine primary care for chronic health

conditions, or their primary care is not well integrated with their behavioral health. As a result, these individuals may experience higher rates of inpatient and emergency department use. To address these deficiencies and better integrate care the Department of Health (DOH) together with the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) are collaborating to facilitate an integrated licensing program. As the Plan is implemented, key staff from these agencies together with representatives of providers and patients will be asked to participate in APC planning discussions to assure integration to best serve these particularly vulnerable populations.

The Plan will consider and, where appropriate, integrate specialized programs for high-risk high-cost Medicaid or dual beneficiaries, with multiple chronic diseases or special needs, including those who are homeless, experiencing extreme poverty and require socially extended care coordination. We recognize that for some of the most vulnerable New Yorkers, the APC model will not be appropriate or sufficient. Hence, the care of such patients would be the responsibility of emerging models such as health homes, managed long-term care (MLTC), and the Fully Integrated Duals Advantage program (FIDA; see Exhibit 15 below). Plan initiatives related to HIT, evaluation, and workforce will also act as key enablers for these patients. Moreover, PCPs will be encouraged to identify and counsel patients eligible for more specialized care delivery models and arrange for short- or long-term transitions where needed. These initiatives will improve access to emerging, more specialized care delivery models in NYS.

EXHIBIT 15: VISION FOR INTEGRATED CARE DELIVERY IN 2020



1 In the long-term, the Health Homes model may have applicability to select commercial and Medicare populations

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The Plan aims to secure "integrated care for all," that is, value-based care delivery for at least 80 percent of New Yorkers. The proposed, multi-staged APC model builds from existing primary care delivery models, and is based on a set of fundamental principles that allow sufficient flexibility to tailor primary care delivery to the specific needs of a patient, within the maximum structural capabilities of their provider.

3. Increase Transparency to Empower Consumers, Payers and Providers

Improving transparency across the health care system and engaging New York's consumers in their own health care is critical to achieving the Triple Aim. New York is targeting five 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. **Increase data availability to enable third-party innovation in transparency tools**
4. **Increase adoption of value-based insurance design (VBID)**
5. **Continue to amplify best practices in self-management of chronic disease**

3.1 DEPLOY A NEW YORK STATE CONSUMER TRANSPARENCY PORTAL

To make value-based decisions, New York must provide consumers not only with cost and quality information, but also support, encouragement, and education to be able to best use that information.

Through this effort we will:

- Empower consumers to make smart benefit choices and become drivers of their own health
- Increase transparency across providers and payers so that all stakeholders can compare costs and quality of care and adjust decisions accordingly

The transparency portal will focus on providing simple and effective information. To drive the effectiveness of this initiative, New York will encourage use of these tools in two ways: 1) by reaching out directly to prioritized consumer segments and 2) by educating and reaching out to providers and community health organizations that play a key role in patients' health care decisions.

3.1.1 Current cost and quality information transparency in the State

New York consumers will be increasingly engaged by payers, employers, and community organizations to make more value-driven decisions about their health care. However, to date, the impact of these efforts is mixed, with consumers

reporting significant confusion, limited access to information, and varying quality of the information provided.[76]

In a recent study grading states on their provider and facility pricing data transparency, New York was one of 29 states to receive an "F",[77] in part because we have no comprehensive requirement for or online tool to access providers' cost and quality data. Many major payers independently provide this information to members, but only 30 percent of consumers access it and less than half of those accessing the information understand how to use it to make plan decisions.[78] Even when consumers seek out this information, most believe that higher costs correlate with a higher quality of service and thus a better decision about their care. They are not aware that this kind of decision making can increase, rather than decrease, their total costs and may not improve their quality of care.[79]

New York has recognized the substantial need for more accessible cost and quality data. In fact, NYS recently released hospital cost and charge data on the Health Data NY portal (http://health.data.ny.gov), an evolving website with links to a wealth of data including hospital discharge data, cardiac data, Prevention Agenda goals, objectives and background data, and data on managed care plan performance. Together this data is intended to improve the quality of care provided to New York State residents.

There is much to be done to evolve this data to assure greatest utility to consumers, providers and payers – necessary to assure realization of the full promise of this plan. To that end, NYS is in the process of creating an all-payer cost and quality portal (see the "Transparency to Empower Consumers" section of this report for a full discussion) as well as a fully interoperable health information network – the Statewide Health Information Network of New York (SHIN-NY). Together, these initiatives along with increasingly sophisticated quality data, will move New York from an "F" rating to nationwide leadership in supporting transparency for consumers, providers and payers.

3.1.2 Driving effectiveness of the portal

New York State has identified several ways to drive the effectiveness of the portal and ensure that we are taking action to support consumers in its use. We will

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[76] Health Care Incentives & Catalyst for Payment Reform; New York DOH.

[77] Ibid.

[78] Ibid.

[79] RWJF, Consumer Beliefs and Use of Information about Health Care Cost, Resource Use, and Value, 2012.

design the portal to ensure that it provides the right information at the right time by doing the following:

- Creating and testing tools to help consumers understand how to use the information to make value-based decisions (including ensuring early consumer input into the design process)
- Providing cost information tailored to an individual's particular health care needs and situation, so that data is relevant to the individual
- Reporting cost information in a way that is consistent and easy to understand. Currently providers use a variety of data points—for example, amount billed, amount covered, amount paid by payer, list price—resulting in substantial confusion
- Designing the portal for use at the time of diagnosis. Research indicates that consumers are most likely to use cost and quality information when facing a new health diagnosis and considering treatment options.

Existing payer access points as well as other states' provider portals indicate that simply having the information available is not enough to drive use. While consumers indicate that they value cost and quality information, significant education and marketing efforts are necessary to motivate them to access it. For example, Minnesota engaged in a substantial marketing effort that included:

- Educating providers on how to better engage consumers on benefit choices
- Engaging with employers and consumers through presentations on cost and quality information and implications
- Convening stakeholders "to improve [our health] system overall through partnerships"
- Branding the transparency effort and conducting an extensive PR effort to raise awareness of it
- Partnering with providers and pharmaceutical organizations to promote the patient portal

While our goal is to have all New Yorkers use the portal to make value-based decisions, and access will be open to all from the outset, we will initially target our marketing and outreach effort to those groups, particularly individuals living with one or more chronic diseases, who have the greatest potential to reduce costs and improve the quality of the care they receive. For these segments, we will launch a high-touch outreach effort to provide initial support in identifying value-based options and ongoing support in accessing and using the portal.

New York will directly conduct outreach to educate consumers and provide direct assistance to those currently making treatment decisions. We will also engage with

organizations and providers who are in a position to work with individuals making future treatment decisions. Through a collaborative effort, we will support local organizations to test interventions that help consumers make just-in-time care decisions about the best sources of treatment.

3.1.3 Near-term priorities

The transparency portal is currently in development as part of our broader set of HIT initiatives. In May 2013 Mana Health's patient portal was selected through a competitive process. This portal should be operational in coming months. Building on Mana's portal, NYS intends to initiate the following over the coming year (2014):

- **Consumer testing and revision**. To ensure the portal is accessible to consumers, we will conduct focus groups as part of the development process to verify ease of use and relevance of information provided. These focus groups will target individuals recently diagnosed with common conditions as well as those who typically rely heavily on emergency room care when other options are available.
- **Stakeholder education.** Providers, health support groups, community health centers, and academic medical centers will play a key role in encouraging recently diagnosed patients to use the portal. To activate these groups toward supporting our engagement objectives, we will:
  - directly engage with major provider networks and health organizations around the consumer benefits of using the transparency portal
  - provide guidance and training on how to talk with consumers about the transparency portal and support consumers' use
  - provide marketing and educational information directly to consumers who use the portal
- **Consumer awareness.** Leading up to and after launch, we will conduct a marketing and PR push to raise awareness of the portal and its benefits
- **Targeted consumer engagement and support.** To drive use of the highest-impact consumer segments, we will:
  - segment our consumer base to prioritize conditions for outreach
  - develop targeted education strategies—including proactive outreach, training to community organizations, and placing accessible materials in communal computer-usage locations (libraries, community centers) for individuals without home Internet access—that offer just-in-time support to each priority segment

- place disease-specific educational materials on portal as part of information providers give to consumers at the time of diagnosis
- consider developing a hotline for direct support to individuals who have difficulty navigating the health care system on their own

Beyond our initial push, we will continue ensuring that the portal information is provided at the time consumers are making care decisions and will refine this information based on utilization rates and the user feedback we receive.

3.2 CREATE A CONSUMER EHR PORTAL

New York State is building a digital network of electronic medical records that will transform how patient care is provided and deliver major cost savings. It's called the Statewide Health Information Network of New York, or SHIN-NY.

In New York, as in many states, most consumers lack direct access to their medical records. This lack of access decreases their ability to monitor and manage their own health. As discussed in more detail in the "Health Information Technology" section of this document, New York has an initiative underway to develop a portal that will allow consumers – and their providers -- to connect with their electronic health records (EHRs). This access enhances consumers' control over their health care decisions and increases the transparency of the entire health care landscape.

The experiences of other countries indicate that consumers require high-touch engagement to learn how to access their EHRs and leverage them to maximum advantage. While 84 percent of consumers believe they should have full access to their EHRs, only 4.7 percent of patients with access use them. Additionally, some physicians have reservations about patients accessing EHRs, with 65 percent of U.S. doctors saying patients should have only limited access to electronic records.[80]

New York is currently planning for its consumer EHR portal to have a provider and consumer opt-in feature, meaning that both the provider and the consumer will have to register to access and modify it. (Compare this with an opt-out approach, where consumers are simply given the information necessary to access the portal.) This design feature increases the importance of reaching out to consumers about the use of this portal, because they must be proactive in setting it up and using it.

We know from U.S. and international experience that a comprehensive engagement effort will be required. New York State will start this effort by enrolling providers, and then shift emphasis to engaging consumers directly. First

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80 Healthcare Briefing.

encouraging providers' access will accomplish two things: 1) create complete records for eventual consumer use and 2) enhance the system with accurate information sharing across providers.

When we shift focus to consumer engagement, we will initially target the highest priority segment of consumers who typically need significant care from a variety of providers and those with chronic conditions who most need the ability to access their own health records to manage their treatment plans effectively. As with the transparency portal, we will work to ensure that economically disadvantaged individuals have access to the portal in locations relevant to them.

3.2.1 Near-term priorities

Over the next six to 12 months, we will focus on identifying the highest-priority cross-cutting challenges and engage with stakeholders on what would most support them in strengthening their consumer engagement efforts in these areas.

Based on these conversations, we will create the forums needed to convene stakeholders around these issues and the approach to identifying and elevating best practices. By 2015 we intend to have the infrastructure in place to address consumer engagement challenges in a collaborative, results-driven way.

3.3 INCREASE DATA AVAILABILITY TO ENABLE THIRD-PARTY INNOVATION IN TRANSPARENCY TOOLS

We believe that our efforts to increase data transparency through the consumer transparency portal and the consumer EHR portal represent two fundamental and necessary steps forward in increasing transparency in health care to empower consumers' informed decision-making. We also value innovation among private payers, providers, or other third parties in designing and deploying their own consumer engagement tools. We believe that innovation across stakeholders will generate a market of good ideas and produce a much-needed abundance of advanced approaches, tools, and applications able to meet the data needs of consumers in the future model of integrated care for all.

The State will consider five mechanisms to facilitate these third-party innovation efforts:

- *First*, we will routinely convene interested parties to collectively assess and prioritize gaps and needs around consumer engagement. We will recognize priorities that apply not only to the general population of New Yorkers, but also to special populations and to specific regional needs.
- *Second*, we will ensure access to the data that third-party developers will need to develop and test their own tools and applications. We will ensure that the

test datasets are appropriately anonymous as needed but robust enough to inform sophisticated development of tools.

- *Third*, we will define and disseminate the minimum technical requirements that third-party consumer engagement tools would have to meet in order to be integrated with our current data infrastructure. This includes but is not limited to the All-Payer Database, the SHIN-NY, and the consumer transparency and EHR tools discussed above.
- *Fourth*, we will continue to create mechanisms to foster innovation, such as incubator competitions or grants that will help to catalyze this work (like the New York Digital Health Accelerator that has supported the development of the consumer EHR portal). We may explore private-public partnerships to support and stimulate such incubator efforts.
- *Finally*, we will seek to review and address existing regulatory requirements that may unnecessarily hinder innovation, so that entrepreneurship is supported through State policy.

3.4 INCREASE ADOPTION OF VALUE-BASED INSURANCE DESIGN

Value-based insurance design (VBID) focuses on aligning an individual's cost sharing (typically co-payments) and/or premium contributions to the value of a particular health service or treatment for that individual. It may also include a program of incentives for employees/members to engage in comprehensive health assessments, preventive care, healthy behaviors, etc. Major payers in NYS are exploring VBID models, but the State has not to date formally encouraged these efforts.

To move VBID efforts forward, reduce the State's cost, and allow for continued innovation, New York will:

- engage with State employee unions to explore whether an opt-in VBID program can be a win-win for the State and its employees
- encourage payers to experiment with and increase offering of VBID plans
- educate employers on VBID and elevate and share approaches that are showing clear results

3.4.1 Current state of VBID in New York

VBID is an emerging area in New York, with payers frequently incorporating its approaches into pharmacy benefits and beginning to incorporate portions into care delivery and diagnostic service benefits. However, VBID programs among payers in New York are not widespread or comprehensive.

3.4.2 Strategy to increase VBID plans in New York

While VBID approaches make a great deal of intuitive sense, empirical results are mixed. With limited comprehensive analysis, one meta-analysis of individual employer results found little-to-no savings from a broad employer-and-employee cost perspective, but did suggest much more promising savings for interventions targeted to high-risk patients.[81]

Individual case studies have provided evidence that well-designed VBID can result in increased drug adherence, fewer major vascular events, reduction in obesity and tobacco use, and a positive return on investment for diabetes-specific spending.[82]

Recognizing the potential long-term impact but current uncertainty around what approaches are most effective, NYS will take a flexible and collaborative approach to increasing its VBID plans. To move the effort forward we will do the following:

- **Initiate collaboration with State employee unions and retiree organizations to consider a VBID opt-in feature of the Plan**. Connecticut successfully worked with its unions to co-develop an opt-in feature that had extremely high employee uptake.[83] The plan offers substantial savings to employees, including a $100 per month reduction in premiums and no co-pays or deductible requirements for medication associated with the management of chronic medical conditions. The Connecticut plan requires that participants obtain specified age- and gender-appropriate health-risk assessments, evidence-based screenings, and physical and vision examinations; undergo two dental cleanings per year; and participate in condition-appropriate chronic disease management services. Members who fail to take these actions will no longer be allowed to select the VBID option and will return to their regular non-VBID plan. Employees can decline the VBID option from the start and stay with their existing plan.

  While there are currently no long-term results, preliminary results saw more than 98 percent of the approximately 54,000 eligible Connecticut state employees and retirees voluntarily enroll in the plan and overwhelmingly comply with program requirements. Primary care visits almost doubled while specialty care visits declined by roughly 20 percent and the increase in health care spending slowed from a 13-percent year-on-year increase to a 3.8-

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[81] Evidence That Value-Based Insurance Can Be Effective, 2010.

[82] The Evidence for V-BID: Validating an Intuitive Concept, 2012.

[83] : V-BID in Action: A Profile of Connecticut's Health Enhancement Program, 2013.

percent increase in 2012. While it is likely that not all of this cost reduction is attributable to the VBID plan, emerging evidence indicates that this plan design has created win-win outcomes for both the State and employees.

- **Encourage payers to increase their offering of VBID plans on the exchange and in their offerings to employers**. New York will work to engage with payers and identify potential incentives that will drive their VBID use. For example, we will explore whether a streamlined Form and Rate Review process or the publication of successful results would increase the use of VBID approaches. Payers need substantial flexibility in using these approaches as they identify optimal ways to implement them, so we will not specify precise requirements for plans to qualify as VBID. We may, however, explore establishing a minimum definition of what constitutes 'VBID', to help ensure that approaches in New York evolve beyond simple no-cost routine exams.
- **Educate employers, employees, and unions to increase demand for VBID.** Employers have much to gain by identifying and using successful VBID approaches. As discussed, preliminary results are mixed and plans can be set up in many different ways, from a very targeted approach with a disease-specific focus (for example, a plan for only diabetic employees), to a broader approach with features that benefit all employees. Building on existing opportunities to convene the State's major employers, we will seek to increase the general understanding of VBID options, address the specific uncertainties and concerns discussed above, and celebrate successes publicly to encourage greater use

3.4.3 Near-term priorities

To work toward the strategy described above, New York will explore partnering with an organization with deep experience in VBID, such as the North East Business Group on Health (NEBGH) and the Center for Value-Based Insurance Design.

To develop successful VBID approaches in New York, we will take the following actions over the next 6-to-12 months:

- Convene a working group with DFS, DCS, the Governor's Office of Employee Relations, State employee unions, and other key stakeholders to explore the potential benefits of a VBID offering. If this working group decides there is reason to move forward, create a process to launch an opt-in offering by open enrollment in 2015.
- Engage one-on-one with key payers to better understand their beliefs about VBIDs, their plans for future VBID use, and barriers or challenges they face in incorporating more of these approaches

- Identify employers in the State that have leading-edge VBID plans or programs in place and engage with them to develop lessons learned from these examples. Create case examples to educate other employers and engage directly with large employers to identify barriers to using VBID plans and ways NYS could support use.
- Engage with providers and community-based organizations in efforts to help their consumers understand and navigate VBID plans
- Continue to monitor results of VBID approaches in other states as more becomes known about VBID's longer-term impact and incorporate that information into New York's approach

In the longer term, if we move forward with a State employee VBID plan, we will target a launch in 2015. By 2015 we also expect to have any payer requirements or incentives in place to encourage additional VBID plan offerings and have a way to disseminate success stories to employers.

3.5 CONTINUE TO AMPLIFY BEST PRACTICES IN SELF-MANAGEMENT OF CHRONIC DISEASE

New York will strengthen consumer engagement in health care by identifying and elevating approaches that work. Currently many New York stakeholders are incorporating consumer engagement programs, but without a clear understanding of what broad approaches work best. Pockets of innovation are occurring throughout the State with approaches and lessons learned that could be leveraged more broadly.

New York will strengthen its consumer engagement efforts in two ways: 1) by supporting the testing of novel approaches that could improve consumers' preventive care and adherence to treatment in areas prioritized in the Prevention Agenda, and 2) convening stakeholders to collaborate within communities and to focus on certain diseases.

3.5.1 Current level of patient engagement in New York

Significant patient engagement efforts throughout the State focus on encouraging individuals to make positive prevention decisions and to effectively self-manage chronic conditions. Several major payers offer prevention incentives, and providers are increasingly offering interactive information via healthy living web portals, on such topics as disease, drugs, healthy living, and symptom management.

Much of the effort is focused on adherence to treatment plans once a diagnosis is made. New York City, for example, is testing electronic pillboxes that alert

pharmacists when doses are missed, and the State's Diabetes Physicians Incentive program is enhancing disease-treatment programs through incentives to physicians to monitor patients more proactively.

NYS is generally taking a disease-specific approach with stakeholders by collaborating with them in the prevention and treatment of particular diagnoses. One notable example is the State's AIDS Institute, which launched NYS HIV Quality of Care (QOC) Learning Networks. These networks build the capacity of HIV programs to improve the quality of patient care and patient experience. The capacity building is achieved primarily through coaching, peer exchange, and trainings conducted during face-to-face meetings with patients and stakeholders, and is augmented by web-based phone conferences and on-site technical assistance. The Learning Networks provide structured environments for group learning and focused quality-improvement activities.

Another State-led approach is the Cancer Services Program, an information clearinghouse for New York residents seeking services in managing breast, cervical, and colorectal cancer. The State provides a consumer hotline to navigate services and collaborates with providers to offer free screenings to qualified individuals. The program also collaborates with, and directs consumers to, local grassroots, freestanding organizations that provide a range of supportive and educational services for individuals diagnosed with breast cancer. Finally, the program directs consumers to local legal and support services for patients and families affected by a diagnosis of cancer and its ongoing treatment.

While the State's support-services activity is significant, outcomes indicate that the level of consumer engagement is not optimal and could be raised. The prevalence of diabetes, arguably our biggest looming health challenge, is increasing at a faster pace in New York than it is in the rest of the country. Historically, New York's targeted prevention campaigns – around smoking cessation and suicide prevention – have generally been quite successful (see the Population Health Status discussion in this report for additional details), and now we need to find ways to use this past experience to tackle our current health challenges.

New York consumers struggle to adhere to their treatment plans, with roughly two-thirds of patients taking their medications incorrectly.[84] Currently, a robust knowledge base on strategies to increase adherence rates does not exist.

[84] New York DOH.

3.5.2 New York's strategy to strengthen consumer engagement

To increase patient engagement and improve outcomes, New York will continue to prioritize working with stakeholders around disease-specific areas, specifically those outlined in the Prevention Agenda. The success of these targeted efforts clearly indicates that New York's efforts to convene and educate stakeholders and directly support consumers in finding resources are worthwhile.

As discussed in the Community Linkages section of this report, NYS is also working to empower communities to identify and direct consumers to local resources. This effort expands the approach, tested and proven in the Cancer Services Program, to aggregate and disseminate local resources more comprehensively.

In addition to these two areas, New York has an opportunity to address consumer engagement more broadly by supporting stakeholders who test, identify, and elevate health care approaches that could be widely applicable throughout the State. Through discussions with stakeholders over the next year, we will explore strategies to build the collective consumer engagement knowledge in New York. One approach is to identify cross-cutting approaches, such as engaging with teens to make smart health choices or encouraging seniors to adhere to treatment regimens, and launch learning networks around these issues. Another approach would include working through the education system to ensure that the next generation of New Yorkers have higher levels of health literacy that better prepare them as future users of medical care. NYS can provide grants to test specific strategies, with the condition that the results be shared within the learning network and published on a public site. Through these collective learning efforts, NYS can drive increased effectiveness in its prevention and treatment adherence efforts for all.

4. Pay for Value not Volume

Traditional fee-for-service (FFS) payment models do little to reward quality or efficiency. On the contrary, they reward providers simply for the volume of services provided, and in fact may inherently disadvantage those providers who deliver higher quality care with lower frequency of complications. It is also clear that current FFS reimbursement is not available for most of the interventions required in APC practices with respect to patient education, self- management support, patient registries and reminders, care management and coordination, advanced access, creating community care linkages, documenting and improving health outcomes, and much more. Experts and theoretical models suggest that under the FFS system, about 30 percent of our health care dollars go to overtreatment, inefficiency, and fragmented care delivery.[85]

Transitioning to a more value-based payment system is integrally linked to our efforts to change the way health care in our State is delivered and furthers the Triple Aim by aligning the financial interests of payers and providers with the health interests of patients. New value-based payment programs can create incentives to encourage providers to focus on effective, efficient strategies to improve health outcomes. Both U.S. and international examples of health care models that use value-based payment reform have shown savings in the range of 6-12 percent of budgeted care costs.[86] Waste reduction is the principal driver of these savings in the form of fewer hospitalizations, lower emergency department costs, higher generic drug usage, and more judicious use of high-cost diagnostics and surgical interventions.

Importantly, value-based payment models can result in substantial increases to provider incomes, as providers share in the value they create by helping reduce

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[85] The Healthcare Imperative: Lowering Costs and Improving Outcomes – Workshop Series Summary. Institute of Medicine, 2011. Berwick, DM, Hackbarth AD. Eliminating Waste in US Healthcare. *JAMA*. 2012; 307(14):1513-1516.

[86] Literature Review (pubmed), AHRQ, press search numerous case studies internationally and in the United States. Examples in the United States include pay-for-performance as part of Horizon BCBS of NJ PCMH, Michigan BCBS, Minnesota Health Partners, Pennsylvania Geisinger PCMH Model, Oklahoma Medicaid PCMH, South Carolina BCBS, CareFirst BCBS PCMH, Colorado Children's Health, and CareOregon Medicaid Primary Care Renewal; Upside and downside sharing in Sacramento ACO and Beacon Pioneer ACO; as well as capitation (or similar) in New York CDPHP, MCMS Massachusetts Alternative Quality Contract (AQC) and Community Care of North Carolina. International examples include NHS Tower Hamlets upfront financial support, Germany "Prosper" upside risk sharing, Valencia capitated payment model in Spain, bundled payment in Netherlands, Taiwan, Italy and Sweden. Horizon BCBS of NJ PCMH, Sacramento ACO, Group Health of Washington, Community care in North Carolina, Michigan BCBS, Colorado CHAP, CareOregon Primary Care Renewal, BCBS Mass. AQC.

patients' total cost of care. Within the Capital District Physicians Health Plan (CDPHP), a provider-owned health plan in upstate NY, providers generated up to 40 percent higher profits through a value-based payment model than they had previously earned through a traditional FFS structure.[87]

Our Plan for shifting from FFS to value-based payment comprises five elements:

1. **Embrace value-based payment across primary care and specialty care for hospitals and other providers.**
2. **Establish a flexible framework for value-based payment for APC.**
3. **Adopt value-based payment for APC within both Medicaid and State and Public Employees.**
4. **Encourage Medicare to make value-based payment for APC more universally accessible to providers.**
5. **Align regulatory processes with adoption of value-based payment.**

Approaches to reinforcing provider transitions to value-based payment will be further explored and finalized in the coming months.

4.1 EMBRACE VALUE-BASED PAYMENT ACROSS ALL TYPES OF CARE

Since 2010, payers within the State have been implementing some 100 pilot programs to supplement or replace FFS payment models with innovative value-based models that shift reimbursement methods from volume to value.[88] Several Medicaid value-based payment models are in place, including a fully funded long-term care model, a shared savings model for health homes, and a patient-centered medical home (PCMH) incentive program that financially rewards practices with NCQA recognition using per-member-per-month (PMPM) payments. Also, most major commercial health insurance companies are either running or participating in pilot programs that link some measure of payment to quality and care coordination.

Most innovative payment models focus on improvements in primary care services. Although around half of these pilots use a pay-for-performance system, some payers are piloting more advanced payment models such as shared savings, shared risk, or global funding models. While these ongoing pilots have shown compelling results, their reach and ROI have been fairly limited, potentially because these

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87 NYS Health Foundation website on October 8: CDPHP presentation on Comprehensive Payment for Comprehensive Care from November 14, 2012; calculation by University of Massachusetts Medical School and Boston University.

88 Preliminary findings from payer survey conducted by NYS Department of Financial Services in 2013.

trials have been implemented relatively recently, with a limited number of practices and patients, and evaluation methods are incomplete.

Although this section addresses payment models with regard to primary care, the State is open to considering if and how payment model transformation might be extended to additional stakeholders, such as specialists, hospitals, and community-based organizations.

4.2 ESTABLISH A FLEXIBLE FRAMEWORK FOR VALUE-BASED PAYMENT FOR APC

The Plan does not prescribe a specific payment model to be linked to the APC care delivery model. Instead, the State will define the minimum threshold of what constitutes a 'value-based payment model', and payers will have the flexibility to design their portfolio of payment models based on the providers and populations with whom they work. As described above, future primary care payment arrangements are expected to be increasingly sophisticated, with a decreasing percent of services paid by FFS arrangements. Specifically, 'value-based payment models' could include pay-for-performance, gain sharing, and two-sided risk sharing (including global capitation). These models may be tailored in line with fine-tuned care delivery models through "mix and match" approaches that include a combination of FFS arrangements and add-on lump-sum payments or PMPM incentives.

The section below illustrates a simplified model, through which value-based payment arrangements could roughly align with the three APC stages. In reality, however, significant variation will exist in the capacity and payment arrangements of individual providers, both within and between APC stages. While there may be standardized "quality gate" standards, it is unlikely that strict borders between payment arrangements of provider groups in different APC stages will be defined. In the future, we will continue to consider the spectrum of models, how they will be supported, and how to achieve the appropriate degree of specificity on payment model guidance.

- **Pay-for-performance** payment models reward providers for meeting or exceeding certain predetermined performance criteria, such as decreased hospitalizations for ambulatory care-sensitive conditions or an approach to reward improvement. Throughout the State, payment incentives are expected to be tied to metrics on process efficiency, quality, and patient health outcomes. While pay-for-performance may not create as much value to the health system as shared savings or risk sharing, we believe it can nonetheless support providers to focus on key metrics in line with high-impact performance goals.

Pay-for-performance payment models are expected to be well suited for many of the same practices that seek pre-APC recognition. Both pay-for-performance payment and pre-APC care delivery are expected to appeal to providers who prefer to take financial and operational responsibility for care delivered primarily in their own PCP offices.

A major barrier to a smooth and timely adoption of pay-for-performance arrangements is the need for a cost-efficient and timely platform for submitting and tracking pre-defined practice performance objectives.

- **Shared Savings** payment arrangements incentivize provider(s) to reduce unnecessary health care spending for a defined population of patients or for an episode of care by managing all needs of the patient and thereby the cost of that patient's care. This model involves payers sharing savings with PCPs for a health care expenditure that was expected but avoided as a result of a successful integrated care model.

  Shared savings payment models are expected to be well suited for many of the same practices that adopt standard APC care delivery models. Both shared savings payment and standard APC care delivery target practices that may not yet have the full capabilities, funding, or scale to manage downside risk for the total cost and quality of care for their full patient panel.

  The main requirement for this model is having transparent and robust payer methods for determining shared savings paid to providers.

- **Risk sharing** payment models involve providers accepting some financial liability if they fail to meet specified financial or quality targets. In a two-sided risk-sharing model, the practice will be responsible for a percentage of the losses if the total cost of care is higher than budgeted. In contrast, a global risk-adjusted capitation model involves prospective payments to a provider for all or most of the care they give to a defined patient panel over a specified period of time.

  Payers are expected to preferentially offer risk-sharing arrangements to providers who have met strict quality gates, including sufficient scale, capital, and capabilities to take on the associated risk. Because of these requirements, risk-sharing payments with significant downside opportunity are expected to be attractive only to a subset of large-scale NYS providers with capital and high-quality integrated care. Such providers may broadly align with the practices interested in caring for patients under the enhanced APC care delivery model.

  Incentives related to risk-sharing models increase a provider's motivation to comprehensively manage all the needs of their patient panel and to decrease the utilization of unnecessary resources. This model is expected to improve the long-term health of large-scale, low-turnover population panels.

The main system-level requirements for risk-sharing payment arrangements are an APC recognition mechanism, health informatics processes, and a business model in which future reimbursements outweigh initial investments.

- **Care coordination PMPM payments,** may be used to complement any of the above reimbursement models. Risk-adjusted PMPM fees for attributed patients are typically an ongoing payment and are calibrated to cover the operational expenses associated with the skills and tools necessary to support care coordination. Both the Adirondack PCMH demonstration and the Multi-payer Advanced Primary Care Practice (MAPCP) program involve ongoing PMPM payment for care coordination.

  These investments and resources can be shared between providers and/or payers. For example, payers may support care coordination payments in proportion to the share of the practice's panel attributed to each individual payer. PMPM payments can be designed with special attribution algorithms to avoid reimbursements by more than one payer for any given patient.

  While each payer will have individual payment arrangements with providers, care coordination PMPM investments may be particularly important for small- to medium-sized practices implementing standard APC. In comparison, investing in pre-APC or enhanced APC providers may provide lower return on investment: Pre-APC providers may not have all the structures in place to effectively implement strategies required of practice transformation or care coordination. Many enhanced APC practices already function effectively and as such, have relatively less need for supplementary support (both parties may be better off putting the equivalent 'value at stake' under a risk sharing arrangement).

4.2.1 Guiding principles for APC Value-Based Payment

The proposed new payment model is informed by three key design principles:

- **Flexibility where possible.** Pricing and payment models are a key source of differentiation for payers, and a critical driver of operational priorities and risk/return for providers. We do not believe there is a single 'best practice' payment model, nor that New York as a whole would benefit from broad-based standardization of payment models per se. Accordingly, the proposed new payment model is designed to maximize the flexibility for payers and providers to enter into mutually beneficial and innovative arrangements, while encouraging a rapid state-wide movement away from FFS payment.
- **Standardization where necessary.** Within the broader objective of payment model flexibility, we believe there are two key areas in which standardization is critical. Firstly, the metrics used to measure and reward practice level performance need to be aligned across payers, at least from the perspective of

any single provider (across cost, quality and utilization, as well as associated structural and procedural measures). Secondly, the broad types of payment models offered to a provider need to have some degree of consistency (e.g. a single provider should not be forced to maintain FFS arrangements with one payer but adopt a risk-sharing arrangement with another). Finally, there needs to be a sufficient offering of alternative payment models from payers to practices to reach 'critical mass,' facilitating the change from strictly volume-based incentives to one that places value on patient outcomes.

- **Financial sustainability.** Any new payment models in the State must be financially viable from both a payer and provider point-of-view. Payment premiums should reflect genuine value created by providers (e.g. by keeping patients healthy, reducing avoidable admissions, and referring patients to high-value specialists), with a sustainable apportionment of upside risk between payer and provider (taking into account upfront payer investments for care coordination and practice transformation).

4.3 ADOPT VALUE-BASED PAYMENT FOR APC WITHIN BOTH MEDICAID AND PUBLIC EMPLOYEES

Our aspiration is for the State to lead the way in value-based payment. We believe the most declarative commitment that we can make is for Medicaid and the Plan to incorporate value-based payment into their payment models. It would serve as an example to commercial payers and Medicare of our fundamental belief in the business case around cost and quality that these models offer to New Yorkers.

For Medicaid, we will carefully consider the current, substantial portfolio of efforts encapsulated by the MRT initiatives and the pending MRT 1115 waiver amendment, and ensure that value-based payment models are well-aligned across all of them. In particular, where there are overlaps in patients served or providers affected, we will create detailed design and technical requirements so that payment approaches explicitly reinforce one another and are not duplicated. Our position is that the APC model will strengthen the impact of existing Medicaid programs on the special populations and safety-net providers they target and produce incremental impact for general Medicaid populations that are not directly targeted by the major MRT and 1115 waiver amendment initiatives. Our goal is to provide Medicaid patients and their providers with at least the same opportunity for integrated, value-based care models that any New York consumer or provider will have. In addition, this meticulous design will extend beyond the payment model to address how to best build synergies in care delivery, care management and coordination, and practice models.

For the Plan, we will ensure that the design process is fully collaborative with all relevant stakeholders, including labor unions, the Division of Budget, and our

private payer partners. We understand that the success of value-based payment requires investment to support practice transformation and care coordination, and that all potential improvements to the health insurance plans of our State employees should be the product of cooperative discourse and design.

4.4 ENCOURAGE MEDICARE TO MAKE VALUE-BASED PAYMENT FOR APC MORE UNIVERSALLY ACCESSIBLE TO PROVIDERS

We are grateful for the leadership and support of the Centers for Medicare and Medicaid Services in sponsoring the State Innovation Models initiatives. As part of our State Health Innovation Plan, we are eager to collaborate with CMS to align Medicare payment for primary care with the models outlined above, to be adopted by New York State Medicaid and the New York State Health Insurance Program.

Medicare currently has a draft rule pending for payment of a care coordination fee to medical homes for management of high-risk populations. We are interested to work with Medicare to understand the level at which care coordination fees will be funded under this model. We are also interested to explore whether enhanced funding levels comparable to those under the Comprehensive Primary Care initiative may be extended to providers that demonstrate strong commitment to work toward APC recognition but who require meaningful upfront investment.

There is already precedent for a number of shared savings and risk sharing models tied to total cost of care, including the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO), and Advanced Payment ACO. In the weeks ahead, we hope to work with CMS to develop a flexible framework by which providers may volunteer to accept shared savings for their Medicare beneficiaries within any of the risk corridors previously allowed under these models. This may involve either opening up eligibility for the Pioneer ACO (previously restricted to select organizations based on application), or introducing a new program that offers similar flexibility for definition of risk corridors.

Under any of these payment models to be introduced by Medicare, it will be helpful to providers to establish common reporting requirements and processes similar to those to be required by Medicaid and other payers participating in New York State's APC model. In addition, we will work with Medicare to aggregate data with that of other payers using the APD, and to develop standardized provider performance reports. Ideally, we will pool performance statistics across Medicare, Medicaid, and commercial payers in order to maximize the reliability of outcomes, measures of quality, resource utilization, and total cost of care. We recognize and wish to align ourselves with the goal of consistency of measures across public and private programs for reporting and payment as a key objective of the HHS directed National Quality Forum Measurement Application Partnership (MAP).

4.5 ALIGN REGULATORY PROCESSES WITH VALUE-BASED PAYMENT

Over the coming 12 to 18 months, the State will align existing and emerging regulatory processes with the goals of this Plan for the adoption of value-based payment. This includes asking payers to describe their investments in value-based payment as part of premium Rate Review (for PPOs), HMO licensure renewals, and certification of Qualified Health Plans (QHPs) for the Marketplace.

In particular, the State will explore the use of the Rate Review process as a mechanism to recognize payers' value-based approaches and investments in care delivery and payment innovation, thereby encouraging adoption of the targeted APC models and associated approach to value-based payment. The State intends to work closely with payers in finalizing the design of this process. The intention is to provide payers flexibility to innovate and autonomously manage their portfolio while at the same time ensuring that the health system as a whole moves away from FFS payment and towards a value-based payment model for health care delivery.

5. Promote Population Health - Connect Primary Care to Population Health Improvement

The Prevention Agenda 2013-2017 sets out NYS's comprehensive approach to population health and prevention and as such provides a pivotal backbone for the State Health Innovation Plan. We believe there is a critical role for the newly defined APC model to strengthen the linkages between the Prevention Agenda priorities and the day-to-day practice of primary care as well as its links to health care systems.

This section describes the importance of connecting primary care with population health objectives and outlines our strategy to do so in five parts:

1. **Strengthen local health planning and increase the involvement of primary care providers**
2. **Develop population health reports and draw on Prevention Agenda community health plans, routinely integrating them with performance improvement efforts undertaken by APC practices**
3. **Build and maintain community resource registries and ensure that APC practices have easy access to them**
4. **Create a formal communication channel between the primary care community, local health planning stakeholders, and local Prevention Agenda partnerships**
5. **Ensure that care coordinators are experts in fostering community linkages**

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Tobacco use, poor diet, and physical inactivity are modifiable behaviors that contribute to one-third of all deaths in NYS.[89] This preventable burden of disease is mediated through both behavior, and social and physical environments that increase risks for unhealthy choices. Because a critical strategy for improving population health and controlling costs is to reduce the number of people entering the medical care delivery system in the first place, community-based primary prevention policies and interventions are critical to achieving population health as well as the cost and quality goals of the Triple Aim.

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89 *Extrapolated using the results published in "Actual Causes of Death in the United States, 2000," JAMA, March 2004, 291 (10) and NYS 2009 death data; Source: NYS DOH presentation to the NYS Public Health Association Annual Meeting 2012.*

The Prevention Agenda in NYS is designed to support such efforts by creating sustainable, effective linkages among clinical providers, community organizations (including schools) and public health agencies as a core strategy to reduce the preventable burden of disease.[90] This strategy is realized through partnerships among organizations that share a common goal of improving the health of people and the communities in which they live.

Furthermore, it has been demonstrated that the impact of these community-based, population-level interventions can be further strengthened by linking them to improved access to clinical preventive services and appropriate medical treatment.[91] The Plan's APC initiative seeks to foster these community-clinical linkages.

Such collaborative partnerships are based on trust, accountability, and aligned incentives, and they offer a win-win-win scenario for participating patients, clinical teams, public health agencies and community organizations. Individuals get better access to preventive and chronic care services. Clinicians get support in offering services to patients that they cannot provide themselves. Community organizations get better connected to the population they serve, and public health agencies provide and gather important data on the community's health and work with their community partners to support interventions toward overall health improvements.

One of the key elements of the Advanced Primary Care Practice Initiative described below will be connecting APCs to local coalitions working on the Prevention Agenda, and providing them incentives and tools to be effective partners in the implementation of their plans.

While these activities will go a long way to improve population health, further opportunities exist to strengthen interactions among primary care clinicians, public health agencies, and community groups across the State. The five-part strategy to accomplish that is articulated below.

5.1 STRENGTHEN LOCAL HEALTH PLANNING AND INCREASE INVOLVEMENT OF PRIMARY CARE PROVIDERS

Local health planning is crucial for aligning local health and health care priorities with community and population health needs. To ensure sufficient primary care linkages within this process, leadership from enhanced APC practices will be incentivized and encouraged to participate in community health assessment and

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[90] http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/.

[91] http://www.uspreventiveservicestaskforce.org/uspstf07/methods/tfmethods.htm.

community service plan development, along with a wide variety of local partners, potentially through a rotating, representative panel of APC leaders.

The Regional Health Improvement Collaboratives (RHICs), recently proposed by the Public Health and Health Planning Council, are one potential avenue for the creation and, in some parts of the State, revitalization of structures to facilitate local health planning. As currently proposed, RHICs would comprise 11 new entities that will serve as a neutral mechanism for convening and coordinating regional stakeholders for the improvement of health care quality and value. They will be tasked with planning and executing regional activities to advance the Triple Aim. Examples of such activities could include publicizing quality, cost, and system performance metrics; supporting regional quality collaboratives; identifying and promoting evidence-based patient and community engagement activities; coordinating with and supporting Prevention Agenda activities, and reducing the preventable utilization of services.

5.2 DEVELOP POPULATION HEALTH REPORTS, AND ROUTINELY SHARE THEM WITH APCs

Population health information is critical to evidence-based local health planning. Regular assessments of population health status and trends at the regional level will enable local health planning groups to proactively adapt their approaches to public health priorities and make needed community linkages. Population health reports also help other organizations understand the needs of the local population and demonstrate the results of any improvements made. The format, location, cadence and publishing agency will need to be discussed among key stakeholders.

One option is to leverage existing community health assessments for this purpose. Another option could be to regularly publish standardized community-level public health dashboards with selected priority population health metrics on Health Data NY, currently under discussion within NYS DOH. Data for such population health reports could come from a range of data sources, including the SHIN-NY, QARR and/or APC scorecard (see the "Performance Measurement and Evaluation" section for details). Other potential sources of data include the Community Health Indicator Reports and the Behavioral Risk Factor Surveillance System, which could serve as the basis to understanding population health at the local level while allowing the assessment of community performance, using State and national health objectives and benchmarks.

5.3 BUILD AND MAINTAIN COMMUNITY RESOURCE REGISTRIES

Community resource registries will enable APCs to quickly and effectively connect patients with community organizations that could provide much-needed

support and services. Typical organizations might include local resources that support healthy eating (green markets, supermarkets, and restaurants with calorie postings), exercise (walking groups, parks, discount gyms, walking and bike trails) and smoking cessation resources (support groups; information sites). There are several federal resources on creating successful clinical–community linkages, and these will be leveraged during the detailed design process. For example, AHRQ's Innovations Exchange includes reports and tools for successful clinical-community collaborations, as well as the CCRM (Clinical-Community Relationships Measures) Atlas to support research and evaluation in the field. The Health Information Tool for Empowerment (HITE, www.hitesite.org) is a resource created for and used by social workers, case managers, discharge planners and other to coordinate and improve care. Other examples of reports and tools include the specific evidence-based policies and strategies outlined in the state's Prevention Agenda as well as the County Health Rankings and Roadmap[92] that provide evidence-based interventions to address population health at the community level, as well as CDC's Guide to Community Preventive Services.[93] These reports and tools can not only help identify community resources but also may help health systems to consider other levers in the community that do not necessarily involve increased use of health care services.

To roll-out such a community resource registry (or registries) the State will facilitate discussions with relevant stakeholders to identify how they might link to new or existing web-based tools (e.g. HIE, Health Data NY, Greater New York Hospital Association's Health Information Tool for Empowerment program).

5.4 CREATE FORMAL COMMUNICATION CHANNELS

Communication among local health planning stakeholders and APCs is critical to help foster implementation of local health priorities. The first step in this process may be as simple as mapping all APC practices to their relevant local health planning entity and establishing regular two-way communication (e-newsletters; intranet links) to help ensure regional priorities are translated into action in the clinical setting. Ultimately, solutions to community health challenges need to arise locally. Making real partnerships happen is important, and the State will provide technical assistance to help regions develop appropriate local mechanisms for ongoing communication and collaboration.

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92 http://www.countyhealthrankings.org/roadmaps.

93 www.thecommunityguide.org.

5.5 ENSURE CARE COORDINATORS ARE EXPERT IN FOSTERING COMMUNITY LINKAGES

Care coordinators need to have the ability to help patients navigate not just the medical home and medical neighborhood but also the broader community. In particular, care coordinators should be familiar with the full set of community-based organizations and support mechanisms relevant to the needs of their population panel and have efficient ways of connecting patients as well as evaluating appropriateness and effectiveness. Examples of specific community-facing activities include:

- Empowering patients to take charge of their own health through culturally appropriate health education and informal counseling
- Tailoring individualized care plans to include referrals to community-based and other social support services, where appropriate
- Collaborating and following up with community-based providers to support utilization of services based on consumer and family needs

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Effective completion of activities such as the ones described above may require longer-term commitment on the ground than more basic APC care coordination models. It will also require the development of governance mechanisms and payment and reimbursement systems that value population health improvements, reward all relevant stakeholders, and are customized to the local community. Hence, community-facing care coordination is expected to encompass diverse roles and community interaction models. For example, it could involve add-on training for existing care coordination staff, or it may involve hiring specific community health workers into primary care practice.

III. Enablers

A. Workforce Development

A strong health care workforce will be the driving engine of health system transformation in New York State. The changes implied by the five strategic pillars all demand a future workforce more advanced and nimble than that which we have today. In response, we have developed a health care workforce strategy in four parts:

1. **Expand the supply of clinically-trained workers in key geographies** by working with providers and educators to change admissions, education, and training programs; sharpen recruitment and retention policies and incorporate telehealth technology to expand the geographical reach of the existing workforce.
2. **Update standards and educational programs** to reflect the needs of delivering the Advanced Primary Care (APC) model, particularly trainings around care coordination, quality and performance improvement techniques, multidisciplinary teamwork, and necessary administrative and business skills.
3. **Identify potential primary care-related workforce flexibility opportunities** by putting in place the infrastructure to test and evaluate workforce models of care and their implications for professionals to work to the full extent of their professional competence.
4. **Develop more robust working data, analytics, and planning capacity throughout the State**

The four challenges that these initiatives address are:

- **Shortages in and maldistribution**[94] of the primary care workforce
- **Gaps in training curricula and the workforce skills base,** particularly around team-based, whole-patient-focused care
- **Lack of flexibility** to enable health care professionals to practice to the full extent of their professional competence and move easily between care settings and geographies

- **Lack of comprehensive workforce data and analytical capacity** to understand and plan for necessary changes in workforce supply, demand, needs, and challenges

The proposed initiatives build on and leverage State initiatives already in place, such as those outlined in the Medicaid Redesign Team (MRT) waiver but will need to go beyond the MRT. These existing efforts go a substantial way toward closing the capacity and capability gaps in the short run. However, new initiatives will be needed to identify and make the necessary systemic changes to the State's health care delivery system for a smooth workforce transition to the APC model and to ensure access to healthcare for all New Yorkers.

The NYS Department of Health will lead discussions with payers and providers, regional planning entities, professional organizations and the State Education Department to review current workforce strengths and to identify opportunities to evolve regulations, training, and scope of practice requirements to ensure a workforce well matched with the health delivery system envisioned through this plan. Although the focus of the Plan outlined in this document is on strengthening the primary care workforce, the State also intends to ensure appropriate capacity and competencies of the specialist care workforce, including mental health, long-term care, and home care and non-traditional care providers such as family caregivers. Close collaboration among care providers using health information technology (HIT) where possible, as well as more traditional communications, will play a key role in the integrated provider network of the future.

A.1 CURRENT STATE OF THE HEALTH CARE WORKFORCE IN NEW YORK

New York State's health care workforce is inherently strong. The State has greater clinician coverage *per capita* than many states and a high-volume, high quality medical education system. However the current workforce is poorly distributed across the State and largely trained in traditional, hospital-based, incident-focused, individual care settings. There is a mismatch between the system's strengths and what will be needed to deliver the State's vision for health care in the future.

At the same time broader structural changes such as hospital closures, the implementation of the ACA, and the evolving model of care are exacerbating these mismatches.

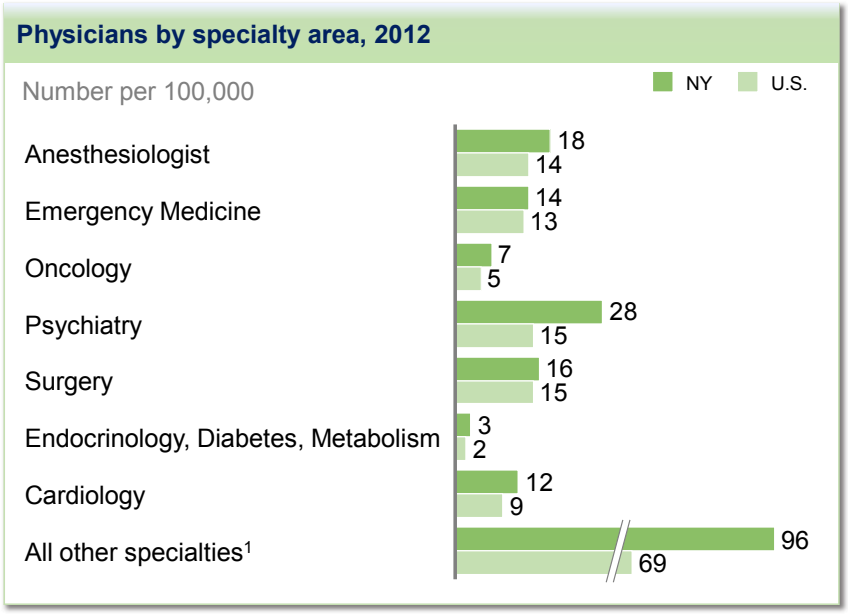
Capacity

Compared with most states, New York has a high number of clinicians per capita. At the State level, this statistic masks the shortages in many localities and some specialties, particularly in primary care.

New York has approximately one primary care practitioner (physicians, PAs, NPs, RNs, and other providers) per 700 people, compared with one per 800 people in the country overall.[95] Similarly, the State has a higher population-to-practitioner ratio across most specialties compared with the country's average, though practitioners are largely concentrated in New York City and are more scarce elsewhere in the State (Exhibit 17).

EXHIBIT 16: SUPPLY OF SPECIALISTS

Supply of specialist physicians in New York State



1 Other specialties include but are not limited to: allergy and immunology, dermatology, geriatrics, medical genetics, neurology, ophthalmology, orthopedics, otolaryngology, pathology, plastic surgery, radiology, and urology.
SOURCE: Kaiser State Health Facts: State Licensing Information from Redi-Data, Inc., November 2012; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social Economic Supplements)

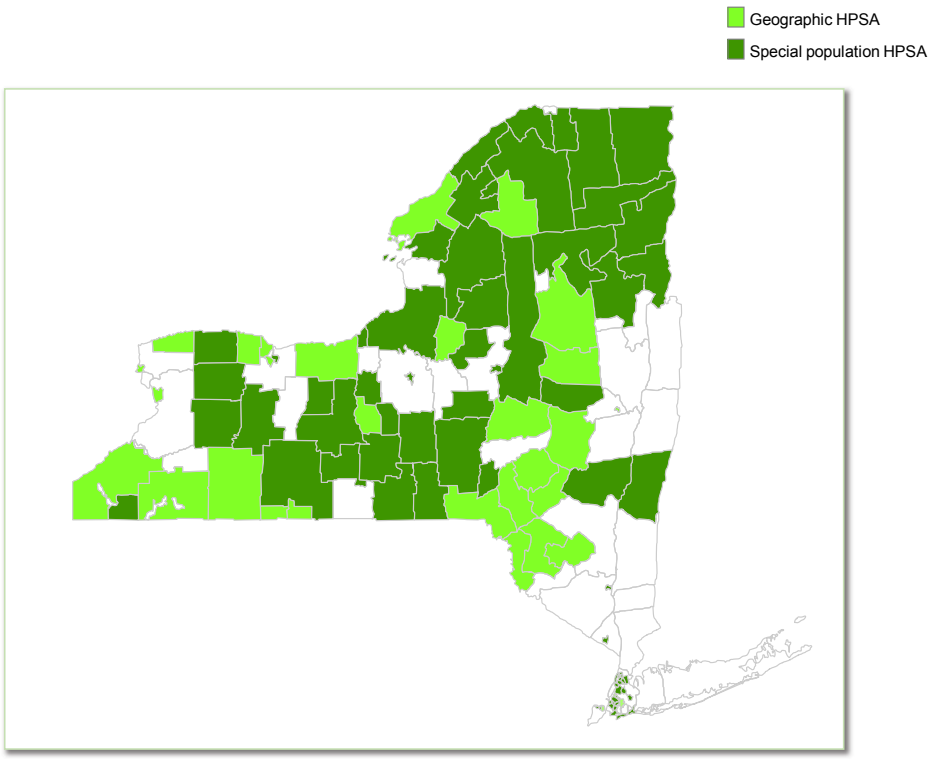
These favorable ratios are partially driven by a high volume medical education system that attracts candidates from around the U.S. and the world. The New York system graduates close to one-third more residents per year than any other state. However, only 44 percent of graduates remain in the State to practice, with many

95 Kaiser State Health Facts: State Licensing Information from Redi-Data, Inc., November 2012; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social Economic Supplements).

citing that the reason they leave is proximity to family and to take more attractive jobs elsewhere.[96]

Despite New York State's relatively healthy physician coverage, we have shortages of health care professionals in specific localities: 92 areas in the State have less than one primary care physician per 3,500 people. This maldistribution is projected to worsen as the older health care workforce serving rural and inner-city areas begins to retire at a faster rate than those practitioners in other locations. According to HRSA data, roughly 1,100 additional primary care providers would be needed in the State's primary care shortage areas to reach an appropriate minimum level of coverage (that is, one physician per 2,000 patients in all locations).

EXHIBIT 17: PRIMARY HEALTHCARE PROFESSIONAL SHORTAGE AREAS



SOURCE: U.S. Department of Health and Human Services, Health Resources and Services Administration, HRSA Data Warehouse (http://hpsafind.hrsa.gov/). Accessed 26 October 2013.

Beyond the primary care and physician specialist workforce, the State has identified shortages in many health occupations including dentists, dental hygienists, health administrative specialists, and health aides. Providers consistently report difficulty in recruiting and retaining workers for most roles, and this challenge is typically most pronounced in non-hospital settings.

96 Center for Health Workforce Studies (CHWS) - University at Albany.

New York has an emerging care-coordination workforce. Some formal training programs, such as the New York Care Coordination Program and the NYS Care Management Training Initiative are in place. These tend to be workshop-focused with the goal of building individual processes or capabilities within a provider. Providers generally incorporate care coordination functions piecemeal and spread them across a variety of individuals rather than designating a specific person as a care coordinator.

The density of the emerging care coordination workforce varies significantly between providers. The exact number of care coordinators in the State is not known. The available evidence indicates that existing care coordinator training and workforce capacity is not sufficient to meet future needs.

Capabilities

New York has a technically qualified workforce but has not historically focused on equipping these professionals with the skills needed to work in the networked, team-based, increasingly primary care-focused model of the future.

Currently the education and training of our health professionals most often occurs in disciplinary silos that focus on specialized clinical roles.[97] This siloed focus interferes with the delegation and collaboration that doctors, nurses, and others need to work as teams; typically these professionals get little guidance on how to interact effectively with each other in support of team care.

While pockets of innovation exist, they need to be better encouraged and incentivized. Current investments in team-based training through initiatives such as the Hospital Medical Home Demonstration program as well training for the non-physician workforce through the health workforce retraining initiative must continue to be supported and encouraged. Medical education must be refined to ensure student exposure to newer models that incorporate group-based decision making and whole-patient-focused care.

Current training tends to be reactive with health providers trained to treat and manage patients who contact them rather than proactively reaching out to patients or the broader community. Consequently the health workers across most occupations lack some of the core skills needed to deliver APC model, including:

- prevention outreach and education
- proactive care coordination and case management
- high-risk/high-cost patient health coaching

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97 Center for Health Workforce Studies (CHWS) - University at Albany.

There are also gaps in technical skills, particularly information technology tools (for example, electronic health records and telehealth technology). NYS is working to identify those providers who are using technology tools and those who are not. Understanding the barriers to broader use will enable the State to develop programs that will promote the value of these technologies and increase IT utilization.

Flexibility

Given the existing and growing shortage of primary care physicians (PCPs), a broader range of professions need to be able to provide aspects of the services typically provided by PCPs today. A recent analysis of the health care profession's ability to practice across a variety of disciplines found that New York State has:

- mismatches between professional competence and State-specific legal requirements of practice
- lack of uniformity in legal scopes of practice across the State for some health professions
- limited ability to support practice overlap across health professions
- slow, even adversarial processes for changing State-specific legalities of practice.[98]

New York's workforce also lacks flexibility in moving between geographical locations and settings of care. Once physicians are established in one location, they have little incentive to change their setting, which perpetuates the State's maldistribution of health care even though its physician-to-patient ratios exceed the national average.[99] Work of the MRT Workgroup on Workforce Flexibility/Scope of Practice will be reviewed and built on to create a workforce appropriate to the proposed care model.

Workforce planning

Beyond physicians, our workforce capacity, supply, and demand are not well tracked, so that both the root causes and most effective solutions for our workforce challenges are not well understood. While the Center for Workforce Studies provides much needed information on workforce needs, more can be done to inform and support the workforce of the future.

We also do not currently have a statewide "one-stop shop" clearinghouse for workforce resources, such as incentive programs, training initiatives, and regional

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[98] Dower, C., Moore, J., & Langelier, M. (2013). It is Time to Restructure Health Professions Scope of Practice Regulations to Remove Barriers to Care. *Health Affairs. 32(11). 1971-1976.*

[99] New York State DOH.

efforts. These resources, where they do exist, are at times undersubscribed simply because the workforce is unaware of them. Without an information clearinghouse, we are limited in our capability to project the supply and demand, consolidate and communicate workforce resources available, and address health care workforce shortages.[100]

New York also has the ambition to more effectively analyze its workforce's readiness for longer-term shifts in health care delivery. Because of limited resources, we tend to focus on near-term challenges, such as hospital closures and the lack of access in some communities, and do not address the longer-term solutions needed to transition toward primary care with a prevention and disease-management focus outside of hospital settings.

A.2 CURRENT INITIATIVES

The State has launched several initiatives to address its maldistribution of health care and workforce inflexibility (these are listed in more detail in the appendix).

Capacity

New York has financial incentive programs in place designed to attract primary care practitioners, specialists, and other health workers to the 99 Health Professional Shortage Areas (HPSAs) and other underserved areas. The programs typically repay educational loans or offer financial grants to practices to promote hiring. Funding for these programs fluctuates significantly, resulting in awards some years and not others. Generally, though, several hundred students receive some form of direct or indirect support every year, typically through funding to providers, through programs such as the Area Health Education Centers (AHEC), Doctors Across New York (DANY).

New York also offers visa waivers to physicians who practice in underserved areas and retraining programs for unemployed health workers. These programs increase our workforce by 30-to-40 physicians each year at little-to-no cost but are capped by federal regulations.

Through the Medicaid Waiver, New York has requested $250 million in funding to broaden its Doctors Across New York (DANY) Physician Loan Repayment and Practice Support program, which provides funding for physicians in underserved areas; the Primary Care Service Corp, which focuses on recruiting non-physician primary care providers to underserviced areas; and other key workforce recruiting and retention programs for underserved areas.

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[100] Healthcare Subcommittee report, http://www.labor.ny.gov/workforcenypartners/swib/healthcare-subcommittee-report-to-wib.pdf.

If approved, this funding is expected to have a substantial impact on the State's near-term shortages, but it will neither completely eradicate them nor address longer-term structural issues.

Capability

New York is investing in capability building in its clinical workforce through the Health Workforce Retraining Initiative (HWRI). This effort provides some $26 million in funding to hospitals, nursing homes, and other organizations to build the capabilities of New York's existing health care workers to take on new responsibilities and provide more effective care. The professions covered include nurses, midlevel practitioners, home health aides, resident assistants, technicians, technologists, therapists, social service workers, and care coordinators.

New York is also increasing its focus on filling the capability gaps that are emerging in its existing workforce as a result of changes in the delivery of care. Through the Medicaid Waiver, New York has requested an additional $250 million in funding to expand the HWRI. This funding will enable the State to build upon existing training initiatives and start to put in place the workforce capabilities needed to support Affordable Care Act, including developing and promoting Patient Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs), and other integrated-care delivery systems. Training efforts will increasingly focus on providing coordinated, culturally sensitive, patient-centered care within the context of Health Homes, long-term care facilities, and broader primary care and public health efforts.

While these efforts are particularly focused on strengthening the workforce in underserved the communities, the skillset developed is broadly applicable to the APC model. As the training is developed, New York will ensure that it aligns with the needs of the APC model and is leveraged to build the skillset across our workforce.

Flexibility

New York recognizes its need to address workforce flexibility challenges. A 2012 report to the New York Workforce Investment Board stated, "Many in the health care field, especially those in direct patient care in New York State, cannot practice to the full extent of their education and competency…the emerging shift from an inpatient, facility-based care delivery system to a care management system gives New York and its stakeholders in the health care system an opportunity [to] redefine the roles of, and develop new roles for, those involved in the delivery of emerging modalities of care."[101]

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[101] Report of the Healthcare Workforce Development Subcommittee to the New York State Workforce Investment Board Transforming the Health Workforce for a New York, March 2012.

As part of the MRT, New York has launched workgroups to identify the potential scope-of-practice changes and propose legislation funding, as appropriate.

Waiver funding will likely be used to support research into the comparative effectiveness of the State's health workforce. This research will offer a detailed analysis of the kind of health care services provided by clinicians and a better understanding of the effectiveness of different health workforce staffing models.

Workforce planning

New York currently has several important efforts to work toward establishing a statewide regionally driven approach to workforce planning and development.

The State University of New York (SUNY), in partnership with DOH and other collaborators, is conducting a series of regional workshops to develop plans that address health care workforce gaps and forecast future needs.

In addition, New York has requested waiver funding to establish a Health Workforce Data Repository that will support ongoing collection, analysis, and dissemination of information about health workforce supply, the education pipeline, and the demand for health workers. This funding will also provide a statewide system for monitoring health workforce demand across all settings of care—hospitals, nursing homes, home care, and ambulatory care sites (clinics, federally qualified health centers, and private practices), as well as local health departments.

Waiver funding will likely also support a statewide study to identify and describe the roles, responsibilities, qualifications, and training needed for new and emerging job titles across all health care sectors as a result of health care reform and the expansion of primary care services throughout the State.

A.3 IMPLICATIONS OF FUTURE MODELS ON THE WORKFORCE

The future care model shifts away from the hospital-based, individual, acute care system prevalent today and toward a new model that focuses on meeting the individual and various health care needs of consumers in the most appropriate settings. The future model of care will incorporate:

- **For the majority of consumers, broad advanced primary care** that provides an accessible entry point into a practice-led approach supported by nurses, including LPNs, RNs, and NPs, who then coordinate with specialists. Primary care providers will provide multi-disciplinary, team-based care and care coordinators will integrate care for consumers across providers and community resources

- **For high-risk, high-cost patients, focused identification and management** through a collaborative care approach that supports individuals with two or more chronic conditions. This care integrates health professionals who will treat the whole person by incorporating community services and family into the health delivery system
- **For consumers with mild-to-moderate behavioral health conditions, primary care-led screening and treatment** that incorporates remote psychiatric consultant support. Primary care providers will screen, diagnose, and treat, mild and moderate anxiety and depression, and psychiatric specialists will provide support as needed
- **For all consumers, prevention efforts** through primary care screenings, conversations, and action plans, and the involvement of health workers who are focused on consumer education

This model will be enabled by better utilization of technology, improved performance tracking, and more effective recognition and addressing of patient needs.

These ambitious changes have important implications for workforce capacity, capabilities, flexibility, and planning. To address these implications, the State will build on existing initiatives in place and already proposed around each of these four key areas. Because of their scale and scope, the pending MRT 1115 waiver initiatives are particularly important to the overall success of aligning the workforce capacity and capabilities to the future care model. The initiatives discussed below extend the waiver efforts, but without the execution of the waiver initiatives, we will face substantial limitations in our ability to implement the APC model because of the capacity and capability gaps in the current workforce.

The pending MRT 1115 waiver largely addresses the challenges through near-term solutions. The initiatives described below are designed to catalyze structural change so New York no longer has to rely on short-term solutions to its health care workforce problems. These will need to be accompanied by a robust evaluation process to ensure effectiveness and value for money.

The proposed actions are described below.

Capacity

Address primary care and specialist physician shortages

In the near term, the $250 million requested through the pending MRT 1115 waiver will make a substantial contribution to closing the nearly 1,100 primary care physician gap as well as gaps in other primary care and some specialty physician occupations.

To deliver medium and long-term sustainability, the State will launch four initiatives:

1. **Explore modifying clinical education admission criteria** to admit individuals most likely to choose to practice primary care in New York. "One size fits all" admission criteria fail to adequately take into account the different skill sets needed by primary care providers and some specialists. Additionally, research from Center for Health Workforce Studies (CHWS) shows that students from New York are most likely to practice in New York upon completion of training; addressing geographical gaps is likely to require a location element to admission. By collaborating with state clinical education institutions to explore ways to include location in admission criteria, more diverse educational backgrounds, and interest in primary care, we may be able to develop a health care worker pipeline primed to fill our gaps.

2. **Increase student exposure to rural and non-hospital settings** by incentivizing and supporting rural hospitals and health centers to create residency and other training programs. Practitioners are more likely to practice in a location where they have trained than elsewhere. Through these programs, future physicians and other PCPs will be exposed to non-urban/non-hospital settings, with the goal of increasing the likelihood they will stay in these settings post-training. An initial pilot will provide the data needed to assess the full scope of this intervention.

3. **Test approaches to increase in-State retention of physicians who complete GME in New York.** New York loses more than half (56 percent) of its physicians to out-of-state residencies every year, despite the fact 95 percent of these residents did not enter their residency with plans to leave the State.[102] While some left because of proximity to family or similar personal reasons, many reported other reasons including better jobs in locations outside of New York, better jobs in practice settings outside of New York, better support in meeting visa requirements, and better salaries elsewhere, as well as a lack of jobs in state. In collaboration with educators, we will seek to identify residents at risk of leaving the State because they perceive the "right" job for them is not here, and provide resources to better support them in finding the right job in New York. We will also work with teaching institutions to better market the variety of potential incentives and opportunities available to graduates.

4. Many primary care providers, including physicians, nurse practitioners and physician assistants are from New York State, complete their training here and want to remain in the state to practice. There are limited data available on the proportion of providers who leave the state after training and the reasons they

[102] Center for Health Workforce Studies (CHWS) - University at Albany.

leave. As part of an effort to keep these providers in the state, we will investigate and identify the most effective strategies to keep them in New York and encourage them to practice in ambulatory settings in underserved areas across the state.

5. **Increase attractiveness of primary care careers in underserved areas** through the potential extension and expansion of the enhanced payment program for primary care providers. Currently the program offering enhanced payment to Medicaid providers expires in 2014. The State will explore extending the program beyond 2014 and expanding it to include all HPSAs, FQHCs, and FQHC look-alikes, as well as explicitly extending its scope to incorporate non-physicians.

In addition, we will continue to develop and test innovative approaches to expand our health care workforce pipeline and increase the diversity of our workforce to better represent the overall population. These efforts will drive pipeline changes that will reduce the need to rely heavily on financial incentives to close primary care and specialist gaps as well as create a workforce that represents our culturally diverse state.

Increase care coordination capacity

To enable the care coordination functions required for APC, the State needs some 2,000-3,000 (FTE) care coordinators in the next three years.[103] Many providers currently have various employees filling portions of this role and have resolved for themselves how to best approach their care coordination needs. However, given the increased emphasis and need for this function across all providers as well as the urgency in which providers will need to strengthen care coordination efforts, the State will convene stakeholders to identify the competencies needed to effectively conduct the care coordination activities. Building on these competencies, the State will engage with health education providers (SUNY, AHEC, REC, and others) to create a curriculum that builds these competencies in both the existing workforce and in newly qualified individuals. Providers will be able to demonstrate their care coordination capacity for APC recognition evidenced through their staff's completion of these courses.

Provide technical assistance to providers for transformation effort

Through the pending MRT 1115 waiver, New York is developing a technical assistance (TA) program for Medicaid Provider hospitals. This program will include learning collaboratives (including virtual learning collaboratives), onsite and virtual coaching, distance learning programs, self-guided training, and practice

[103] Based on experiences in other health systems, one coordinator can support 5,000 to 10,000 consumers, implying that New York would require 2,000-3,000 to cover 80% of its population.

coaching, and will cover the wide range of business management, technology, and process challenges faced in transitioning toward an APC model. New York will build upon this existing effort to offer the TA to all providers for appropriate fees. Providers will be able to leverage the TA workforce and services in tailored ways to meet their individual practice's needs. Providers will be able to demonstrate their capabilities for APC recognition through the use of the TA resources.

Encourage pooling of resources across providers

To drive efficient use of New York's limited workforce resources, the State will encourage small providers to pool resources around office management, care coordination, social services, and other related functions where full-time support is not needed or is uneconomical. The State will test approaches to most effectively help providers create these networks and help workers be successful. Through demonstration projects and existing examples, New York will develop a regionalized approach to minimizing underutilization of workforce resources.

Capabilities

Develop the current workforce's clinical and patient-care capabilities

Using the training curriculum development described above as a foundation, New York will collaborate with existing health care educators and training organizations such as AHEC and Associated Medical Schools of New York (AMSNY) to address clinical and patient care training gaps. Through these collaborations, we will identify the specific skills (including team-based care, behavioral health care, and prevention efforts) and curriculum required, and will work collectively to find ways to offer appropriate support to our existing workforce. To incentivize participation, we will encourage payers to complete relevant CME modules needed to meet APC requirements. For providers other than physicians, a recognized and standardized education and training requirement would need to be developed.

Develop the current workforce's business management and IT capabilities

Similar to the clinical and patient-care capabilities, we will work with educators to ensure resources are available to develop skills in performance management, HIT utilization, and approaches to operate a business successfully within the new payer model. We will collaborate to pinpoint the skill gaps among most providers today based on feedback from early adopters and TA efforts supporting hospitals. Educators will then create and adapt new and existing curricula to fill these skill

gaps. For APC recognition, providers will demonstrate that these skills exist within their practices either by completing training or in their actions.

Align the future workforce with the needs of the APC model through collaboration with educators and training resources. As the State started to do with SUNY, we will initiate a dialogue with public and private universities, colleges, and other public and private health occupation organizations to support them in aligning their curricula to the state's future workforce needs. Given the extensive health care education system in New York and the overall shift throughout the country toward more team-based, value-driven models, this effort should be attractive to educators who can increase the competitiveness of their graduates in the job market through innovative programs. New York State will further encourage these efforts by publicly recognizing and celebrating unique and novel approaches.

Flexibility

Increase role flexibility and scope overlap in relation to primary care services

New York will develop an ongoing process for the assessment and testing of potential changes in health professions regulation to encourage workforce flexibility in primary care services. Working with the State Education Department (SED), New York will support demonstrations of potential workforce models and identify outcomes that indicate opportunities to improve the efficiency and effectiveness of care through evolving workforce flexibility standards.

Increase geographical flexibility by enabling tele-health networks

One way to increase access to specialized care is through the use of tele-health. New York will support this initiative by engaging and incentivizing specialists to use tele-health, working with payers to align provider compensation to the care provided, and ensuring that our practice and privacy regulations enable the use of tele-health. Through the IT capability initiatives we will ensure our workforce is prepared to use emerging tele-health technologies.

Workforce data, analytics, and planning

A common theme throughout these initiatives is the need for increased capacity to develop a comprehensive understanding of our current primary care-related workforce and identify the implications of systemic changes on our workforce needs. To fill these gaps we will build on the initiatives in the pending MRT 1115 waiver with the following targeted primary care initiatives.

Drive the effectiveness of the Health Workforce Data Repository through data reporting requirements for clinician registration / licensing renewal applications. Currently, our data collection survey is optional, resulting in significant data gaps

in the portion of our workforce focused on primary care, particularly for non-physicians.

Increase New York's capacity to test and evaluate models of care. To identify and strengthen the impact of the workforce initiatives proposed in the Plan as well as other DOH efforts, we will build our capacity to conduct demonstration efforts, and identify and disseminate findings from them.

Develop New York's capacity to identify and address the implications of major structural changes. As discussed, New York is facing several major structural changes, including hospital closures, the implementation of the Accountable Care Act, and evolving models of care. To ensure that we align our workforce to these and future changes, we will invest in basic research to understand the implications of each shift.

A.4 CATALYZING PROVIDER BUY-IN AND TRANSFORMATION

Systemic changes to our health care landscape require difficult adjustments. Change can be challenging and temporarily disruptive to staff and to productivity. It is incumbent on us to be transparent regarding what we currently know about existing PCMH work with primacy care practices. That will require both honesty and planning. For the initiatives discussed above to become viable, our health workforce must understand and believe in the purpose of these efforts. In addition to the incentives and requirements already discussed, we will launch a strategic communications initiative to raise awareness of and alignment with the APC model. Key efforts will include:

- **Articulating the business case for change and the benefits for providers**. We will reach out via webinars and direct interactions to engage provider groups and professional associations in a dialogue about these changes. Where change is successful, we will celebrate that achievement.
- **Learning from early adopters**. We will interview providers of different sizes and in varied locations to capture their change stories and disseminate them in public communications.
- **Identifying and communicating lessons learned**. We will be transparent in our change initiatives to enhance efforts and demonstrate flexibility and continual improvement to the new health care model.

We will monitor the attitudes and mindsets of our workforce to ensure alignment with the APC model. If there are gaps, we will identify root causes and address these issues either through outreach efforts or by adapting the model.

A.5 NEAR-TERM PRIORITIES FOR PLANNING AND IMPLEMENTATION

Workgroups are underway for the initiatives already proposed in the waiver. For the new initiatives addressed here, we will take the following actions over the next 12 months:

- Capacity
  - Engage with educators and build off existing working groups for conferences focused on expanding clinical education admissions criteria and identifying approaches to increase primary care focus and in-State retention
  - Engage with rural providers to identify opportunities to create non-urban residency programs
  - Evaluate feasibility of extending and expanding enhanced payment to providers in underserved areas
  - Define care coordinator competencies and engage with educators to develop and market training programs
  - Develop technical assistance defined in the pending MRT 1115 waiver and create approaches to expand offerings to all providers in a cost-neutral way
- Capabilities
  - Refine existing educational modules to support both clinical and business management capabilities
  - Test modules with focus groups from across health professions and engage with professional associations to adapt as needed
  - Continue engagement with SUNY and other stakeholders to explore innovative approaches to align curriculum to future needs that could be replicated elsewhere
- Flexibility
  - Review tele-health survey currently being fielded to identify barriers to increase use and develop initiatives to blast past these barriers
  - Develop demonstration programs that would allow providers to practice to the full extent of their competencies and assess the impact on quality of care and service delivery
- Workforce data, analytics, and planning
  - Identify and prioritize key systemic questions for focus in increased workforce investment

- Provide support to programs piloting innovative models in education, changes to workforce flexibility, and provider operations to identify and elevate models that work

NYS will continue its capacity ramp-up and expanded capability efforts identified in the pending MRT 1115 waiver while we address and solve our existing workforce challenges through 2018. The areas of focus discussed above will lay the groundwork for the next six to 12 months for long-term systemic change plans we need to achieve our statewide health care goals.

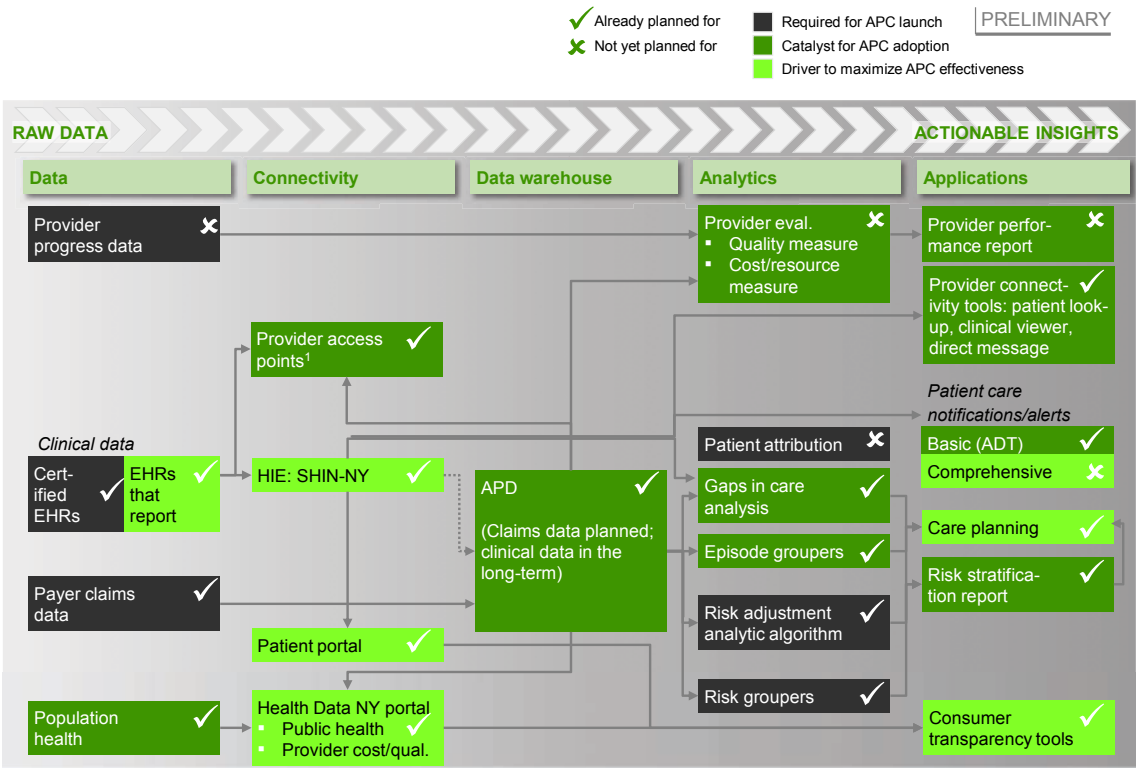
B. Health Information Technology

The near- and long-term success of the Plan rests squarely on the extent to which we can effectively evolve and leverage Health Information Technology (HIT). The State has taken strides to strengthen and expand its HIT over the past decade, including promoting the adoption of electronic health records (EHRs) and investing in infrastructure and collaborative policy development to enable a health information exchange (HIE). The State plans to continue its commitment to providing best-in-class HIT functionality to support patient care coordination and to advance population level improvements in the quality of care delivery, systemic cost-control, and health outcomes. We will reach best-practice systems by ultimately making available data actionable and easily accessible to payers, providers, and patients.

On an already robust HIT agenda, we aspire to go further. Specifically, the State will continue to advance the following HIT strategic priorities:

1. **Encourage the adoption of certified EHRs**, including the participation in Meaningful Use by eligible providers and hospitals.
2. **Promote provider participation in bidirectional health information exchange** with the State Health Information Network of New York (SHIN-NY) by substantially decreasing the cost of participating in the HIE in three ways: 1) leading the development of interoperability standards for EHRs, thereby substantially decreasing the cost of connecting to the HIE; 2) hopefully receiving waiver and other funds to assist with the costs and process of connecting to the HIE; and 3) creating a public utility model to eliminate ongoing interface costs and provide new tools for providers.
3. **Implement an All-Payer Database** to better assess health and health care across NY and inform planning, program/policy development, and evaluation through analytics and visualization tools.
4. **Ensure that patients have access to their personal health information** through a patient portal so they can be active participants in their own care.
5. **Enable consumer choice** by delivering tools that allow patients to compare the cost and quality of care, make informed choices about their care, and serve as an additional check on spending without value.
6. **Make government datasets (cleansed of personally identifiable information) publicly available** to encourage transparency and innovation in research and discovery
7. **Enable the operation of the APC model** by providing support for APC recognition as well as any new resources needed for progress tracking and evaluation.

EXHIBIT 18: BEST PRACTICE HIT SYSTEM AS ENVISIONED FOR NEW YORK



1 All tools listed under "Applications" (except for consumer transparency) have or will have some kind of "provider access point," e.g. a portal or interface

B.1 EHR ADOPTION

Clinical data is currently being collected by providers in EHRs and made available to community providers (with consent) and for public health purposes through connections to the HIE. Providers face two costs associated with EHR adoption: 1) an upfront acquisition, implementation, and adoption outlay of between $10,000 and $15,000 per provider and 2) an annual usage fee of $6,700 per provider, based on experiences of the Regional Extension Centers (RECs). There are additional costs associated with connecting to the HIE, which are discussed later in the "HIE Adoption section," below.

Beginning in 2006, the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) capital grant program provided some financial support to providers to promote EHR adoption. In 2011, the federal Meaningful Use program began providing incentives to eligible hospitals and providers to adopt EHRs, up to $44,000 over five years for Medicare providers and $64,000 over six years for

Medicaid providers.[104] By July 2013, more than $900 million had been paid in EHR incentives to 22,000 providers in New York State. The Office of the National Coordinator for Regional Health Information Technology's (ONC) Regional Extension Centers (RECs) assist priority providers (those with sufficient Medicaid and/or Medicare patients) in selecting an EHR vendor, installing the system, and learning to use it meaningfully. Based on REC experiences, this service costs about $5,000 per provider, and RECs hope to reach more than 5,000 providers by early 2014. Financial penalties are scheduled to take effect in 2015 for Medicare and Medicaid providers who do not transition to EHRs. Providers also have indirect incentives to adopt EHRs. For example, the care management planning that health homes are required to do is facilitated by an EHR, as is the process for obtaining PCMH certification. Overall, 67 percent of PCPs have EHRs, although only a portion of these are certified EHRs or used meaningfully. Specifically, only 48 percent of PCPs use EHRs for prescriptions, labs, and notes.[105]

These initiatives, however, will likely not be sufficient to achieve 80 percent EHR adoption across the state. Additional options to encourage adoption are available. First, REC services could be expanded to subsidize costs for additional providers. Alternatively, providers reporting on Meaningful Use standard quality-of-care indicators could be linked with payer reimbursements, indirectly incentivizing adoption of EHRs for which this reporting is standard. Finally, EHR adoption could, over time, be directly mandated as a requirement for licensure, with sufficient mechanisms in place to ensure enforcement.

B.2 HIE ADOPTION

The SHIN-NY consists of a network of 11 Regional Health Information Organizations (RHIOs) that serve various regions across the State by connecting EHRs. HEAL grants provided seed money for the initial infrastructure investments and the governance activities that informed statewide policy guidance for RHIOs. HEAL also provided funding to accelerate qualified provider connections to the RHIOs. Adoption has varied by region. Unfortunately, many providers only download data from the RHIO and do not contribute data to the community. The more data that is available via the RHIO, the higher the value to participating providers. The ability to upload data does require a high initial financial output from the providers as well as an annual maintenance cost. To date, some 80 percent of hospitals in the State have connected to RHIOs, but only about 20 percent of physicians have done so.

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104 http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms.

105 SK&A office-based physician directory, May 2013.

The sun-setting of the HEAL grants program on January 1, 2014 will require new approaches to continue to operate and regulate the SHIN-NY, including support for the statewide governance process, the ongoing augmentation of services, and continued provision of adoption promotion and support.

As such, New York is transitioning its HIE to a public utility model, in which the State combines and manages the infrastructure. Ongoing efforts include:

- Proposing a suite of regulatory and legislative measures to establish statewide governance and expand SHIN-NY adoption. Specifically, new regulations will require any entity regulated by the DOH that has a certified EHR system to be connected to a RHIO. Accompanying statutes include establishing a certification process for RHIOs; ensuring that standard services required for public funding are provided; providing authority for the SHIN-NY to use a statewide consent model; creating a State contracting exemption; determining penalties for violations of patient rights; establishing an additional funding stream; and providing immunity for reliance on SHIN-NY. This regulation is expected to be ready to be enacted in 2014; the writing has been completed and an informal vetting process has begun with key stakeholders. Because providers regulated by the Department of Education cannot be regulated by the DOH, the State is currently contemplating the introduction of legislation to ensure that those with certified EHR systems connect to the HIE. Roll-out of this legislation will likely take several years.
- Developing and providing **dial tone services** to all qualified entities. These include provider capabilities to **look up patient records**; **message securely** between one another; manage patient consent; **receive notifications for ER, inpatient, and outpatient events**; provide identity management and security; view public health information; and receive results in a user-friendly Clinical Viewer. These services are core enablers of coordinated care, as they allow for easier management of clinical data and enhanced provider ability to keep track of patient needs. Additional tools, such as more comprehensive notifications and care coordination tools (i.e., using clinical data for real time tracking of high-risk patients and indicators to support gaps in care analysis) may be developed over time. Some RHIO pilot demonstrations related to these tools are in progress at the regional level, which will provide the foundation for these analytics and tools.
- Developing and providing **member-facing services** to all qualified entities. These include legal and information-sharing agreements, ongoing monitoring and audits, marketing and recruitment, adoption and usage support, user training, user support, and governance.

Although current RHIO capabilities are sufficient for APC launch, increased participation in the SHIN-NY will maximize the effectiveness of the State's APC plan and will be a focus over the coming years.

B.3 ALL-PAYER DATABASE

Currently, a variety of public and private organizations collect siloed, inconsistent, and often duplicative information about the State of New York's health care system. The development of the All-Payer Database (APD) will support the collection of claims[106] data in a standard format across payers, allowing for the individual rather than the payer to be the focus of the analysis of health care utilization and cost. New York State enacted legislation in the spring of 2011 that allowed for the creation of an APD. Regulations are being developed to allow for the collection of claims data from commercial health plans.

The State is now in the planning stages for an All-Payer Database (APD), which will initially serve as the clearinghouse for claims data, creating a streamlined process of data collection, cleansing, and storage. The APD will be an essential component of health care payment reform, providing the information that enables analysis and understanding of pricing structures and the impact of new payment models (for example, to determine if a new payment model is bending the cost curve). It will enable several types of analysis including: evaluation of care delivery and payment models, research on the effectiveness of treatment options, and monitoring of public health status and strategies.

There are three components of the APD that will need to be resourced and developed: data intake, warehousing, and analytics. Discussions about fully funding the APD are ongoing. Various potential financing sources exist and are being explored, including grants; cost sharing with Medicaid, CHIP, and the Health Benefits Exchange; allocation of HCRA funding; and other potential funding sources. In addition, we are exploring potential revenue generating models that can be leveraged to ensure long-term sustainability.

The APD collection of claims data will begin with the Qualified Health Plans that participate in NY State of Health. Data collection will then be expanded to Medicaid managed care, Medicaid fee for service, and commercial plans.

Claims data analytic capabilities are required for the success of the APC model. Ultimately, the State intends to provide the platform for various stakeholders to conduct these analyses across payers and providers in a streamlined manner. As cross-provider and payer capabilities are developed, providers may continue to independently perform data analyses. This short-term solution is suboptimal

[106] Post adjudicated claims.

because provider-driven analytics will likely vary in quality and reliability, but can be useful while statewide capabilities are created and rolled out.

Patient attribution methodologies will allow for the determination of which patients should be considered under the care of a specific provider. The development of a standard methodology for determining who is included in a provider's "panel" will be necessary for provider-specific analytics. It is anticipated that a variety of stakeholders will be involved in developing an attribution algorithm.

Two broad APD-enabled analytics and reporting categories have been identified that will provide information to support the APC model. Since this data is not received on a real-time basis, new data sets will be available on a quarterly or monthly basis. Such reports will be constructed with thought to respecting competitive dynamics. These analytics include:

- **Risk adjustment** will use claims data to analyze differences between payers' clinical risk groups and determine the appropriate payer rates and risk adjustments. These analytics include the development and use of risk adjustment algorithms and risk groupers.
- **Care coordination** will use both clinical data (for real time coordination, as described above) and claims data to allow providers to better understand the care needs of their patients. Claims data will support claims-based gaps in care analysis (tracking services received and comparing with patient needs). This will ultimately be supported by the APD analytics solution.

Additional clinical analyses could also support the APC model, many of which are currently only done at the provider level. In the long term, EHR data may also be collected by the APD, which would enable broader clinical analytics. The inclusion of this data within the APD may require additional regulation or legislation. Such inclusion would better enable comprehensive care coordination analytics and risk stratification reporting, which would allow for even stronger identification of high-risk and high-cost patients and determination of care gaps.

A fully functioning APD will be a critical catalyst for APC adoption. Data collected and stored centrally will allow for a smoother, more holistic, and more meaningful analytic process. If the APD is not available at APC launch, providers may be able to coordinate with their respective payers to use their own claims data for some of the above-mentioned analysis in the short term. The APD will enable a far more robust, reliable, and consistent set of analyses and reports and is thus critical for the long term. Further details regarding the design, capabilities, timeline, and resourcing for the APD are currently being considered, and an overall APD plan that clearly links to the timeline of APC rollout will be published in the coming months.

B.4 PATIENT PORTAL

A **patient portal** will allow consumers to access their health records and provide them greater insight into and understanding of their own care. Currently, some EHR vendors create their own portals to allow consumers to interact with their providers online. The State intends to create one common portal, allowing consumers to be able to see all of their clinical data in the same place.

In May 2013, the New York eHealth Collaborative sponsored a competition to select a statewide patient portal where consumers would have full access to all of their personal history (for example, lab results) from all providers. The winning portal, developed by Mana Health, is expected to be operational within the next six months for a select group of providers, with access expanding across the State over time.

The portal may require guidance from DOH to permit laboratory results to be automatically populated into patient portals. Currently, in New York State, lab results can be released only to the ordering provider; they cannot be released to consumers without written permission from the ordering provider. The use of blanket permission forms may solve this issue in the interim. A movement at the national level is attempting to address State laws such as those that prohibit consumer access to their health information. Guidance is expected within the next year.

B.5 COST AND QUALITY PORTAL

Consumer transparency will maximize the effectiveness of APC. New York, a national leader in transparency, is working on an anticipated **cost and quality transparency website** supported by a CMS Cycle III grant awarded in September 2013. This site will be a combined effort by Health Research, Inc., DOH, and DFS, and will serve two functions:

- Creating a DFS/DOH financial and rate-setting module to integrate quality, efficiency, and pricing data with Rate Review using data from the All-Payer Database (APD)
- Publicizing health care-pricing data to consumers. A report from the Catalyst for Payment Reform and the Health Care Incentives Improvement Institute gave NYS a grade of "F" relating to State laws and policies for price transparency.[107] This new site, a web-based platform designed with consumer input, will provide consumers with the information they need to review and compare provider cost and quality data across the state. The first phase of the

[107] http://www.hci3.org/sites/default/files/files/Report_PriceTransLaws_114.pdf.

site is expected to launch in early 2015 and enhancements will be ongoing. Ultimately, these data may become accessible via the Health Data NY website (described below).

This portal will also be developed with respective competitive dynamics, where possible.

B.6 PUBLIC HEALTH DATA

Public health program data, such as registry data, electronic reportable laboratory results, disease surveillance, and population-level health survey data is collected by DOH, the New York City Department of Health and Mental Health (NYC DOHMH), and 57 local public health departments to monitor the health of their communities. This data is used to estimate the magnitude of health problems, assess the extent to which the prevalence of an illness within a population is due to preventable or treatable conditions, determine disease incidence, identify trends over time, assess service delivery, identify high-risk populations, understand patient populations of a health provider, and conduct research. This data is collected from a number of sources, including providers and hospitals.

Some clinical information is also available to providers from selected public health registries at DOH and NYC DOHMH. For example, the Child Health Information Integration program makes available data on every child's immunizations, blood lead screening laboratory test results and newborn hearing screening assessments. DOH is in the process of making additional data available to providers such as WIC enrollment and participation, and newborn metabolic screening results.

New York has recognized the importance of sharing data to advance external research and discovery efforts that can benefit the health of all New Yorkers. In March 2013, Governor Cuomo issued Executive Order 95 to make additional data public and link all public data to its backup dataset. Since then, the **Health Data NY** website has released a variety of data sets to the public (for example, baby names and hospital cost data). Health Data NY is the only site in the United States solely used for health data and received the first annual Health Data Liberator Award from the Health Data Consortium. In September 2013, Statewide Planning and Research Cooperative System (SPARCS) data was posted to the Health Data NY website to give consumers a basic view into hospital discharges.

B.7 APC RECOGNITION AND EVALUATION

Successful rollout of APC requires allowing providers the capability to be deemed eligible. The criteria are described in the "APC Eligibility Criteria" portion of the

"Provide Integrated Care for All" section, will be refined in coming months, and ultimately set by the State for all providers. Once set, individual payers will determine whether they will engage in a new payment model with a particular provider; the State will provide some advisory support for this process.

APC providers will be evaluated regularly, as described in the Evaluation section, below. The section describes the data required for a comprehensive evaluation, which largely pulls from existing evaluation-related data requests but includes a new care performance tool. Evaluation reports will also be produced on an annual or semi-annual basis.

Again, any such new evaluation asks will require additional resources, even if the only change to the current system is to streamline existing evaluation data submissions. Once exact criteria are aligned, the required incremental resource needs will be further refined.

B.8 SPECIAL PROVIDER SITUATIONS

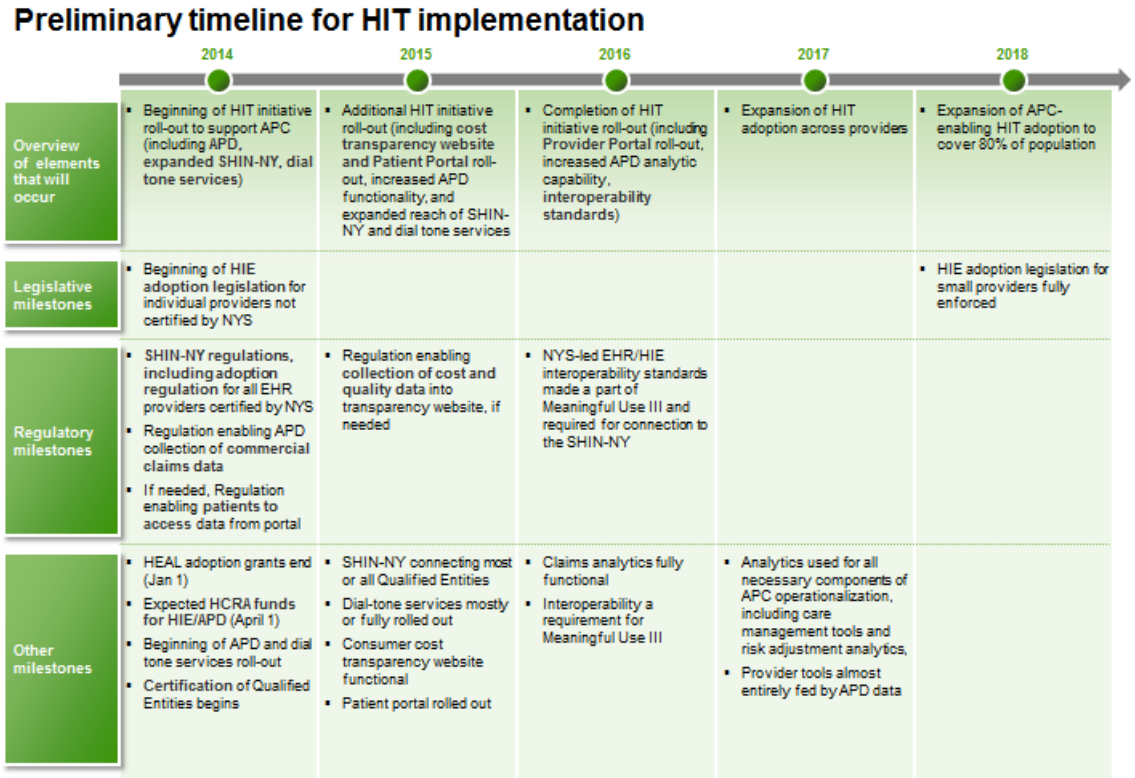
New regulation and potential legislation may ultimately require that all providers with a certified EHR connect to the HIE. Increased REC or REC-like support as well as financial assistance will aid adoption for harder-to-reach providers (such as rural providers).

B.9 MEDICAID ADMINISTRATIVE SERVICES (MAS – NYS MMIS)

The procurement of a Medicaid Administrative Services vendor to operate the NYS Medicaid Management Information System (MMIS) will provide the impetus for the shift of encounter reporting from the current MMIS (eMedNY) to the APD. Medicaid Managed Care Plans that are currently submitting Medicaid and CHP encounters in a NYS proprietary format to eMedNY will begin using the national X12 and NCPDP standards for reporting encounters and submitting those files to the APD Data Intake vendor.

B.10 NEAR-TERM PRIORITIES FOR PLANNING AND IMPLEMENTATION

EXHIBIT 19: HIT IMPLEMENTATION TIMELINE



NYS, which currently operates one of the country's most innovative HIT systems, is planning to invest heavily to expand the system and, in turn, optimize statewide adoption of the APC model. The expanded HIT system will feature an APD; enhance transparency among payers, providers, and customers; and lead in interoperability standards. The State plans to support a range of stakeholders in installing and using the system to maximum advantage, with the aim of reducing health care expenditures while improving the health of all New Yorkers.

C. Performance Measurement and Evaluation

Our State Health Innovation Plan is a significant undertaking at multiple levels and depends on the participation of multiple stakeholders. Therefore, our approach to measurement and evaluation must capture the breadth, depth, and complexity of our ambitions, establish evidence of positive or negative impact, and generate insights to fuel future improvements to the Plan. Our approach is based on four guiding principles:

1. **Measure both progress of the transformation as well as impact against the Triple Aim.** To achieve this, we will ground the Plan and APC measurement in a small, efficient, evidence-based, core set of metrics. New York's health landscape is heterogeneous across regions, consumers, providers and health systems, and payers. A complete set of measures required to account for this heterogeneity would be unmanageably large; therefore, we aspire to produce a common, core set of standardized measures applicable to all settings statewide, and in particular across all payers—Medicaid, NY-SHIP, Medicare, and commercial payers. The core set's scope of measurement will be focused on the structures, processes, and outcomes that we believe would reflect a high-functioning integrated care system. Provider-, community-, or payer-specific additions appropriate to the local needs may be added, but the core set will remain intact. In addition, to the greatest extent possible, measures will leverage established, validated measures and benchmarks (for instance, from National Quality Forum, Healthcare Effectiveness Data and Information Set, Consumer Assessment of Healthcare Providers and Systems, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality[108]) to allow for national benchmarking. While we realize there will be deviations at the margins, where absolutely necessary, and that standardization will be a difficult process, we believe it is worth the effort to improve alignment, and reduce confusion and waste with respect to quality measurement activities.
2. **Build from existing efforts while standardizing where possible to reduce provider burden and increase comparability.** First, we presume that initial and ongoing implementation of evaluation will be most likely to succeed if the provider administrative burden is minimized. Therefore, we will involve the provider community in the development and finalization of the Plan and APC measurement approach. Second, we will build and adapt from existing NYS approaches. We will root our measures and measurement approaches in

[108] NQF: National Quality Foundation; HEDIS: The Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Health Providers & Systems; CDC: Centers for Disease Control; AHRQ; Agency for Healthcare Research & Quality.

systems that already function well within the State. These approaches include those currently implemented by:

- **The State**: for instance, the Quality Assurance Reporting Requirements (QARR), the Medicaid Redesign Team (MRT) metrics, CMS 'Core" Medicaid measures, and the Prevention Agenda metrics
- **Multi-payer medical homes within the State**: for instance, in the Capital District-Hudson Valley-CPCi or the Adirondacks Region Medical Home program
- **Commercial payers**: for instance, those measures currently used in pay-for-performance, gain-sharing, two-sided risk sharing, or capitated value-based payment models
- **Medicare data**: for instance, select measures from the Long-Term Care Minimum Data Set, as appropriate, and the OASIS instrument related to home health quality

We anticipate that use of these measures, already in place or proposed, will allow Plan implementation to capitalize on existing infrastructure and protocols and ease acceptance across stakeholders.

3. **Enhance transparency to consumers, communities, providers, payers, and the State.** Measurement and evaluation will provide the inputs necessary to develop actionable insights for consumers, providers, and communities. We will prioritize analytics and reporting that produce insights that empower consumer decision-making; enable communities to pursue fact-based local health planning; enable providers to navigate cost and quality within the medical neighborhood on behalf of their patients; inform payers on the effectiveness of their support and incentives for provider transformation; and guide the State as it leads the evolution of the Plan.
4. **Emphasize rapid cycle evaluation over long-term academic evaluation.** In order to achieve this, we will first ensure that evaluation serves as the basis for continuous performance improvements. We hold that measurement should not simply be evaluative; rather, it should inform continuous improvement efforts by stakeholders at different levels (for instance, providers, payers, and communities) to improve the structures and processes necessary to achieve the Triple Aim goals. Second, we will aim for the right balance of utilizing statistical rigor and producing practical, timely insights. We understand that establishing causal linkages within the broad-based Plan and its many elements will not be straightforward. Therefore, we will strive to apply rigorous methods to establish control groups, isolate intervention effects, and reduce random effects. But we will do so in a way that still produces timely, routine, actionable data. We will work with quality measurement experts, statisticians,

economists, actuaries, and health policy researchers to maximize the richness and robustness of our measurement approach.

What follows are: an outline of how the evaluation approach will be developed and finalized; a summary of our current work to arrive at a core set of standardized metrics; and a description of the operational support that will be necessary to implement performance measurement and evaluation.

C.1 DEVELOPING THE MEASUREMENT AND EVALUATION APPROACH

We will continue to lead a collaborative process across stakeholders to develop a consensus about the core set of metrics needed to evaluate the Plan and the APC model. Our collaborators include provider, payer, community, and public health partners, and, where appropriate, the supportive technical assistance from the Center for Medicare and Medicaid Innovation. This group will consider how to reconcile all potential evaluation metrics into an optimal list including prevention measures, and allow for regional flexibility and priority-setting. Operational requirements will also be determined during this time. Our target date to finalize the core set of metrics for providers is July 2014. This will allow sufficient time for the State and its stakeholders to refine the data collection, analysis, and reporting infrastructure in time for launch in 2015.

The sets of metrics published below represent our work to date. For each of the State Health Innovation Plan and APC evaluation methods, we have constructed a balanced approach to measurement across the respective goals and elements. We have also balanced measures of structure, process, and outcome because we realize the need to validate early progress toward goals that may ultimately take years to achieve. We believe this work adheres to the guiding principles outlined above.

C.2 EVALUATING STATEWIDE HEALTH SYSTEM TRANSFORMATION

We frame our current approach to evaluating the progress and impact of the overall Plan in two ways:

- **Balanced measurement of Triple Aim impact and of the transformation process to get there**. We include measures of improved health, better health care quality and consumer experience, and lower costs, as well as of system transformation (for example, the proportion of New Yorkers covered by a value-based, integrated care delivery model; the proportion of payers participating in transformation efforts; the geographic reach of various Plan initiatives).

- **Comprehensive measurement of the five strategic pillars and three core enablers.** The Plan is a broad-ranging one. We first attempt to envision successful progress across each of the pillars: access, integrated care, transparency and consumer engagement, value-based payment, and health care connected with the community. Where appropriate, we draw on already existing measures specific to the initiatives that comprise the pillars. Only where absolutely necessary, will we develop new measures. Second, we will develop measures to track the progress of the core enablers: health care workforce strategy and health information technology (HIT).

At the highest level, the Triple Aim goals are

- To achieve or maintain top-quartile performance among States for adoption of best practices and outcomes in disease prevention and health improvement within five years
- To achieve high standards for quality and experience, including a greater than 20 percent reduction in avoidable admissions and readmissions within five years; and
- To generate $5 to $10 billion in cumulative savings by reducing unnecessary utilization, shifting care to appropriate settings, and curbing increases in unit prices within 10 years.

Progress on the five strategic pillars reflects our focus on system transformation:

- **Access**: reduce by 50 percent the proportion of adults without a usual source of care; reduce the size of our uninsured population by 1 million; and substantially reduce waiting times at safety net providers
- **Integrated care**: ensure 80 percent of the population receives their health care services through an integrated care-delivery model
- **Transparency and consumer engagement**: engage 20 percent of consumers in using the Cycle III transparency website or the patient portal, and achieve 80 percent PCP active engagement with the Health Information Exchange or the All-Payer Database (APD).
- **Value-based payment**: ensure 80 percent of health care spending is contracted under value-based payment models
- **Connecting health care with the community**: connect 90 percent of PCPs to high-quality registries of community health-focused organizations

Exhibits 20 and 21 depict our current work on producing an overall State Health Innovation Plan dashboard, including a detailed list of measures in addition to the core measures discussed above.

EXHIBIT 20: EVALUATION DASHBOARD I

New York State Healthcare Innovation Plan Evaluation Dashboard

(for Triple Aim and Strategic Pillars)

High-level State goal

The Triple Aim	Category	Metrics
I. Improve health	Overarching Goals	Quartile performance on core aspects of public and preventative health
	Prevention	Commonwealth Fund's Prevention and Treatment ranking (quartile and state rank)
	Population health	Commonwealth Fund's Healthy Lives ranking (quartile and state rank)
II. Improve care	Overarching Goals	Medicare Hospital Admissions for Ambulatory Care Sensitive Conditions per 100,000 Beneficiaries
		Medicare 30-Day Hospital Readmissions as a Percent of Admissions
III. Reduce costs	Overarching Goals	Percent cost reduction compared to projected baseline
		Cumulative savings compared to projected spend
	Long-term trend	Out of pocket costs for consumers (as a percent of median income)
		Relative resource use for people with diabetes
		Relative resource use for people with hypertension

Strategic pillars	Category	Metrics
1. Improve access to care across the State	Overarching Goals	Percent of adults without a usual source of care
		Number of uninsured New Yorkers new covered by health insurance
		Waiting times for safety-net providers
	Insurance Coverage	Percent of non-elderly population insured (0-64)
	Safety net	Percent increase in low income consumers accessing healthcare
		Percent of adults who did not get care because of cost
2. Ensure integrated care for all	Overarching Goals	Percent New Yorkers in a recognized, integrated care model
	Care delivery transition	Percent PCPs designated Pre-APC, Standard APC, or Premium APC
		Patients answering "yes" when asked if they know who their PCP is
		Percent of patients eligible enrolled in Health Home or FIDA
3. Make healthcare transparent to empower consumers	Overarching Goals	Percent consumers using transparency or patient portals to inform decisions
		Percent PCPs actively engaged with APD and/or HIE[1]
4. Pay for value, not for volume	Overarching Goals	Percent of total healthcare spend linked to value-based plans
	Providers	Percent PCPs enrolled in P4P or shared savings model
	Payors	Percent spend covered by payors incentivizing through value-based payments
5. Connect healthcare with the community	Overarching Goals	Percent PCPs using locally maintained community resource registry
	Payors	Residents living in counties with an up-to date community resource registry (as percent of NY population)
		Percent of PCPs making on average at least 3 referrals per month

EXHIBIT 21: EVALUATION DASHBOARD II

(for Core Enablers, System Transformation and Market Structure)

Core enablers	Category	Metrics
A. Workforce strategy	Primary Care Physicians	PCPs per 100,000 residents
		PCPs per 100,000 residents in HPSAs
B. Health Information Technology Adoption	APD	Percent of providers captured in APD
	HIE	Percent of providers with HIE capability
		Percent of providers having adopted medication e-prescribing
	Patient portal/cost transparency	Percent consumers actively using transparency website/patient portal for health decisions

System transformation and market structure	Category	Metrics
Participation rates	Providers	Program penetration with providers (% covered lives that participating providers represent)
	Payors	Program penetration with payors (% market share that participating payors represent)
Market structure	Providers	Number of practices affiliated with practice group or health system
		Average number of PCPs per practice
	Payors	Number of payors insuring at least 5% of all commercially covered lives

C.3 EVALUATING THE ADVANCED PRIMARY CARE MODEL

Our approach to evaluating the APC model is consistent with our approach to evaluating the Plan overall. In creating the APC Performance Tool, we seek to balance measurement of both progress and outcomes related to the Triple Aim. However, the APC Performance Tool is more granular, because it must provide a detailed platform for providers to understand their progress toward successfully integrating care and instituting value-based practices.

The Plan measures outlined below are based on those established in QARR and MRT in 2012. We then cross-referenced and supplemented them, while avoiding unnecessary redundancy, with CPCi metrics, Collaborative Care model metrics (to reflect the Plan's behavioral health focus), and Prevention Agenda metrics (to reflect the Plan's focus on integrating the care delivery system with population health priorities). The resulting set of measures reflects our focus on a number of priority areas:

- **Improving health**. Measurement will focus on health outcomes (for instance, mortality and functional status), disease burden (for instance, incidence and/or prevalence of major chronic conditions), and behavioral factors (for

instance, smoking). Sample measures include rates of utilization of preventive services and prevalence of health behaviors and risk in the population.

- **Improving health care quality and consumer experience**. Measurement will focus on capturing the patient experience (for instance, from consumer surveys) and on quality care (for instance, using process metrics for safe, effective, timely, equitable, and patient-centered care). Sample measures include rates of preventable admissions and readmissions; the presence of effective care coordination and quality care transitions; the use of e-prescribing; and timeliness of access.
- **Lowering costs**. Measurement will focus foremost on (a) reducing the total cost of care (on a risk-adjusted basis when measured at the provider level), (b) the primary drivers of high costs: avoidable admissions and readmissions; ambulatory-sensitive emergency department visits; resource use related to high priority diseases like diabetes, asthma, and hypertension; generic pharmaceutical use; and diagnostic testing; and (c) the consumer burden of cost: premiums and additional out-of-pocket cost burden.
- **Measuring mild-to-moderate behavioral health conditions**. Measurement will focus on tracking progress of the Collaborative Care model (as adopted by the highest-level enhanced APC practices). These measures will reflect practice implementation of appropriate depression screening, diagnosis, treatment, referral, and continuity of care.
- **Addressing the Prevention Agenda 2013–2017**. Measurement will address all focus areas of the Agenda for which APC practices can be reasonably held accountable: (a) preventing chronic diseases (including heart disease, hypertension, diabetes, asthma, obesity, smoking, and colon cancer); (b) promoting healthy women, children, and infants; (c) promoting mental health and preventing substance abuse; and (d) select components relating to preventing sexually transmitted diseases and vaccine-preventable diseases.

We expect that in the ongoing design finalization process, the measures will continue to be refined to produce consensus on the core set of standard APC measures.

For purposes of discussion, Exhibits 22 and 23 depict a draft version of the APC Performance Tool. We envision that this tool would be provided to APC providers of all levels (pre-APC, standard APC, and enhanced APC) on a periodic basis. Performance data would also be aggregated to produce a payer-level APC Performance Tool. This tool will enable payers to refine their approaches to supporting practice transformation and care coordination, and enact quality and performance thresholds in value-based payment.

EXHIBIT 22: PERFORMANCE TOOL I

Advanced Primary Care performance tool
(for Improving Health)
(for Improving Care and Reducing Costs)

Reported to all, but only Premium APC practices held accountable

				Type of metric		
Triple Aim	Category	Measure Name	Measure steward	Structure	Process	Outcome
Improving Health	*Diagnosis and treatment*	Asthma Medication Ratio	HEDIS			
		Medication Management for People with Asthma (% patients receiving` asthma controller medication)	HEDIS			
		Appropriate Testing for Children with Pharyngitis	HEDIS			
		Cholesterol Management for Patients with Cardiovascular Conditions	HEDIS			
		Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	HEDIS			
		Comprehensive diabetes care - HbA1c control (<8.0)	HEDIS			
		Comprehensive diabetes care - LDL-c control (<100mg/dL)	HEDIS			
		Prenatal Care in the First Trimester	NY specific			
		Persistence of Beta-Blocker Treatment after Heart Attack	HEDIS			
		Controlling High Blood Pressure (below 140/90)	NQF; HEDIS			
		Percent of BH patients for whom a psychiatrist has consulted with PCP on care plan	OMH			
		BH patients in a care coordination program who are receiving medication and/or psychotherapy, 6mos	OMH			
		Medical Assistance with Tobacco Cessation				
		Diabetes long-term Complications	CMMI			
		Use of Tobacco Cessation Strategies				
	Prevention	Chlamydia screening in women (ages 16-24)	HEDIS			
		Childhood Immunization Status	HEDIS			
		Pre-diabetes screening (HbA1c test for at risk patients)				
		Flu Shots for High Risk Patients (Adults Ages 50 – 64, children, pregnant women)	CAHPS			
		Well-Child Visits in the 3rd, 4th, 5th & 6th Year1	HEDIS			
		Well-Child Visits in the First 15 Months of Life1	HEDIS			
		Adolescent Well-Care Visits1	HEDIS			
		Breast Cancer Screening	HEDIS			
		Cervical Cancer Screening	HEDIS			
		Colorectal Cancer Screening	HEDIS			
		Behavioral Health Screening – PHQ2 or PHQ9				
	Population Health	Percent of public school children in NY state who are obese	NY specific - reported to DOE			
		Weight Assessment and Counseling, entire population- BMI Percentile	HEDIS			
		Percent unintended pregnancy	NSFG			
		Percent preterm births	HEDIS			
		Low Birth weight Deliveries (*A low rate is desirable)	CDC			
		Maternal mortality rate per 100,000 births	CDC			
		New diagnosis of HIV	CDC			
		Percent cigarette smoking by adults	CDC			

EXHIBIT 23: PERFORMANCE TOOL II

Advanced Primary Care performance tool
(for Improving Health)
(for Improving Care and Reducing Costs)

Reported to all, but only Premium APC practices held accountable

				Type of metric		
Improving care	*Experience*	Advance Directives Determination				
		Advanced care planning for elderly, high-risk, high-cost and special needs patients				
		Office offers same-day urgent but non-emergency appointments				
		Adult Access to Preventive/Ambulatory Care	HEDIS			
		Children and Adolescent Access to Primary Care Practitioners	HEDIS			
		Care coordination	CAHPS			
		Care Transition – Transition Record Transmitted to Health care Professional	AMA-PCPI; CMMI			
		Care coordinator on site with patient				
		Getting care quickly	CAHPS			
		Satisfaction with personal doctor	CAHPS			
		Post-discharge Continuing Care Plan Created	CMMI			
	Quality	Getting needed care	CAHPS			
		Discharge follow-up (from hospitals and community health organizations)	CMMI			
		Evidence-based referral process				
		Medication reconciliation	CMMI			
Reducing costs	*Hospital utilization (Savings ($) from declines*	Emergency Department Visits - -all ages (per 10,000)				
		Hospital All-Cause unplanned readmissions, risk adjusted	HEDIS			
	PQIs	PQI (Prevention Quality Indicators) score	AHRQ			
	Pharmaceuticals	Generic drug usage				
	Resource use	Relative resource use for people with diabetes	HEDIS			
		Relative resource use for people with hypertension	HEDIS			
		Diagnostic testing utilization				

C.4 OPERATIONAL SUPPORT AND IMPLEMENTATION

Measuring and evaluating the Plan and the APC model across the State will require a high level of leadership, coordination, and supporting IT infrastructure.

How the State will finalize the core set of metrics is discussed above. We will incorporate input from multiple stakeholders. We envision that the Office of Quality and Patient Safety (OQPS) within DOH will be pivotal in working to align payers, providers, and communities on the core set. OQPS will also help to develop the data collection, analysis, and reporting approach.

C.4.1 Sources of data

Data collection will marshal multiple sources of data. In some cases, the systems and infrastructure are already in place to implement data collection, aggregation, analysis, and reporting to stakeholders at various levels. In others (for instance, data on processes occurring within APC practices), we intend to further refine

over the coming months the design, operations, and technical requirements necessary to support measurement.

- **Claims data on utilization, cost, and vital statistics**. Optimally, this data will be sourced through the APD. Before this resource is fully functional, we will source data from the Statewide Planning and Research Cooperative System (SPARCS), which currently aggregates data from inpatient facilities, ambulatory surgery facilities, and emergency departments.
- **Electronic health record data**. Optimally, this data will be sourced through the Statewide Health Information Network for New York (SHIN-NY). Before this resource is fully functional, we will draw on data from the Regional Health Information Organizations (RHIOs).
- **Additional quality data**. OQPS currently manages the collection of data on quality performance from commercial payers and health systems. We expect this process to continue. We also anticipate that APC practices will carry out routine reporting to track their progress in enacting structural and organization practice transformation and in integrating advanced care coordination activities. We recognize that we have further work to do to define and operationalize these processes to ensure the collection of accurate and insightful data in a feasible, efficient manner.
- **Patient experience data**. Critical to capturing the quality of patient-centered, well-coordinated, safe, timely, and effective care will be the use of consumer experience surveys. We will consider targeted focus groups at the health system, practice, and community level; and site visits to APC practices. Regional health planning entities may help to facilitate these local assessments. In addition, we will need to integrate population- and community-level data on access for vulnerable populations and on equitable care delivery, without disparity.
- **Administrative data from statewide care delivery models**. Data on program enrollment and ongoing participation in integrated care programs—including APC (across payers that are participating in the APC model), Health Homes, FIDA demonstration, Behavioral Health carve-in, and Delivery System Reform Incentive Program (DSRIP)—will provide insights on the penetration and reach of these value-based, integrated care models across consumers, communities, regions, payers, and providers.
- **Administrative data from health IT resources**. We will track levels of participation and engagement by stakeholders across the spectrum of health infrastructure resources that the State is supporting: the SHIN-NY, APD, patient portal, Cycle III transparency website, online community resource registries, and various State- and payer-level provider connectivity channels.

- **Workforce intelligence data**. We will track statewide and regional data on health workforce supply and demand, with particular focus on identifying progress in health professional shortage areas and in communities where health disparities persist today; on both the clinical and the allied health workforces; and on primary care workforce capacity, including those roles necessary to succeed in APC models.
- **Department of Financial Services (DFS) data**. DFS will supplement measurement on Plan progress by helping to track payer involvement in overall APC participation as well as models for value-based payment, value-based insurance design, and transparency efforts.
- **NY State of Health data**. Enrollment data will help the State to measure its progress toward providing health insurance coverage to as many New Yorkers as possible.

Data collected through these sources will inform overall Plan evaluation and the APC Performance Tool. The data will also inform additional analytics and reporting efforts, including (a) the Cycle III Transparency website, so that consumers have visibility into cost and quality performance, and (b) regional health planning efforts, such as those that may be instituted through Regional Health Improvement Collaboratives as well as those coordinated by the Public Health and Health Planning Council.

C.4.2 Infrastructure and reporting

Extensive analytic and reporting infrastructure will be needed to create accurate, actionable insights to present to stakeholders at multiple levels. Where processes can be aligned across stakeholders, and where centralization of capabilities capitalizes on benefits of statewide scale, the State will consider taking a leadership role to invest in and manage these functions. Where such capabilities are not yet feasible, the State will facilitate the alignment of payers and other stakeholders on common approaches for the collection, analytics, and reporting by each payer.

The frequency or reporting balanced the imperative to provide stakeholders with timely, actionable data and the necessity of designing a streamlined process with minimal administrative burden.

- Evaluation of statewide health system transformation will occur on a semiannual basis. Results will be publicly posted on a state-sponsored website.
- Evaluation of the APC Model will occur on an annual basis. We anticipate that producing provider-level reports with valid, reliable data will require an annual cycle of collection as well as sufficient extensive infrastructure to

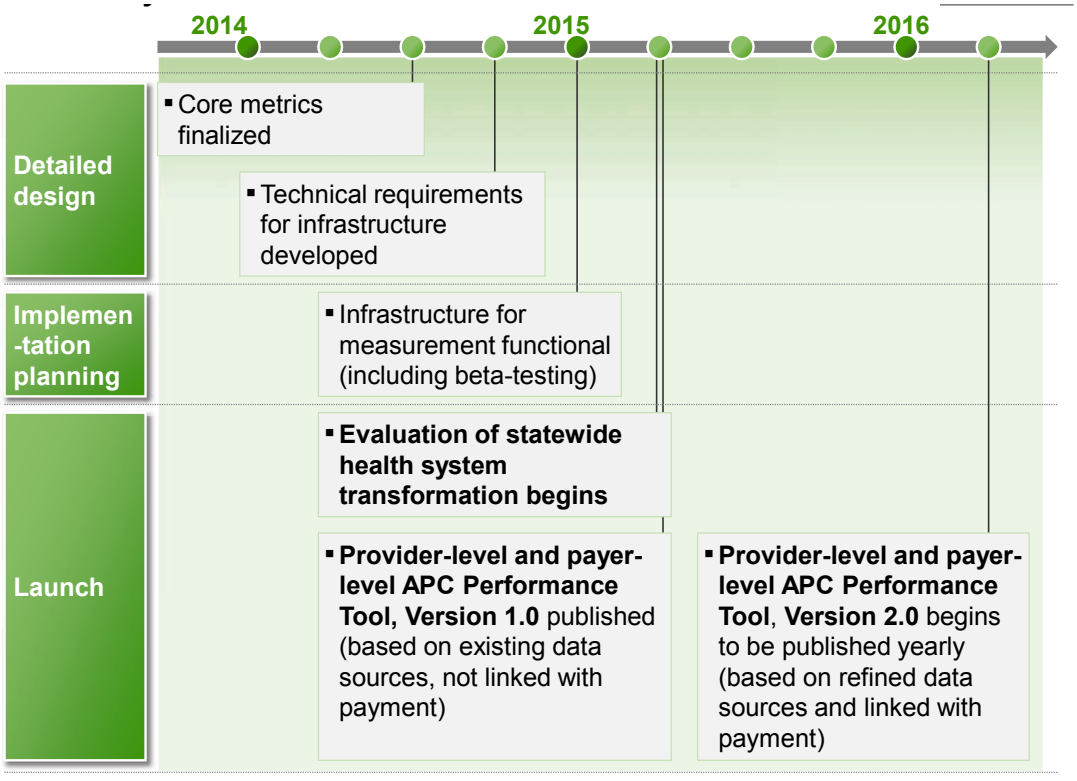
support implementation. During initial rollout and/or beta-testing, we anticipate that results of the provider-level APC Performance Tool will be posted to a secure website accessible only to the provider being evaluated. We expect that NYS, in collaboration with stakeholders, will expeditiously develop an approach and infrastructure to publicly report performance. In addition, we anticipate an annual production of a payer-level APC Performance Tool that aggregates for payers the performance of providers with whom they contract. We recognize that this is contingent on timely completion of the APD, which remains a State priority.

Lastly, OQPS will work to ensure that the State has adequate technical expertise and resources to carry out measurement and evaluation on a sustained basis, including after current and potential federal funding has ended.

C.4.3 Near-term priorities for planning and implementation

The timeline to prepare for, launch, and further evolve the performance measurement and evaluation approach for both the Statewide Healthcare Innovation Plan and for the APC model is outlined below in Exhibit 24.

EXHIBIT 24: MEASUREMENT AND EVALUATION TIMELINE



IV. Transformation Roadmap

1. Governance

Our State Health Innovation Plan is both ambitious and complex. Effective delivery over the next five years, and in particular during the critical start-up period over the next two years, will require extensive collaboration and coordination both within the agencies of New York State, and across the regional and statewide stakeholders that constitute New York's health care landscape. As a State, we have demonstrated the ability to execute on large scale transformations multiple times in the past: we know how challenging it is, but we also know what it takes. Importantly, we know that a key enabler of success is a clearly-defined governance model, coupled with a high-powered, high capability delivery office that ensures cross-system integration, collaboration, and overall delivery against the plan.

Our governance model for the delivery of the Plan has four key components:

1. **Interagency coordination:** we leverage the fact that we are starting 'ahead of the game', as one of the few states that has public health, Medicaid and the Office of Quality and Patient Safety all integrated into a single agency structure. We also push beyond this, to draw in the close collaboration of the Department of Financial Services (DFS), the Department of Civil Service (DCS), and the Division of the Budget (DOB). Additional health-related agencies, including the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), will be involved as well. Our governance model is designed to harness the 'best of the best' – combining clear, department-level accountability for delivering specific Plan initiatives, with a high-caliber, well-resourced Delivery Office that is both empowered and accountable for driving collaboration and coordination at the precise inter-agency and inter-department interfaces where this is critical to delivery success.
2. **Public-private collaboration:** the input of key stakeholders – payers, providers, purchasers, consumer advocates and other key organizations representing the healthcare industry – is pivotal both to the finalization of Plan design, and its effective implementation. Following in the successful model of the MRT, we will establish strong, formal mechanisms for these stakeholders to materially shape the Plan process. Initially, these will take the form of formal payer and provider 'Steering Groups', with clearly defined decision rights and collaboration processes.

3. **Regional input and tailoring:** we anticipate that there are a number of decisions and actions that our stakeholders want undertaken at a regional level. To the extent that this is agreed upon during the detailed design phase, we will formalize governance mechanisms with regional entities to empower and support them in their contribution to delivering the Plan. In particular, we anticipate regional entities playing pivotal roles in determining local health improvement and quality improvement priorities, as well as in choosing vendors for practice transformation and care coordination.
4. **Program Delivery Office (PDO):** we believe that a high capability, well-resourced and empowered program delivery office is essential for steering us to on-time, impactful delivery of the Plan objectives. This will necessitate a dedicated office within the DOH. The office will facilitate inter-agency collaboration, collaboration with our external stakeholder Steering Groups, and interactions with regional entities.

This section defines the following four elements in detail:

- **The guiding principles and processes** by which we have defined our approach to governance and program delivery.
- **The overall governance architecture** for delivering Plan initiatives
- **Proposed mechanisms for optimizing public-private collaboration, and regional tailoring**
- **The role of the Program Delivery Office (PDO)**

The following sections lay out the framework for the proposed governance structure. Further specificity will be established in the coming months, particularly regarding the role of regional entities as well as the specific scope, scale, and operating model of public-private steering groups and the PDO.

1.1 GUIDING PRINCIPLES FOR GOVERNANCE MODEL DESIGN

Our approach to governance model design is informed by three simple, but powerful, underlying beliefs about what it will really take to deliver our State Health Innovation Plan.

- **Only the tightest, highest degree of interagency collaboration will suffice:** hence, sponsorship will reside in the Governor's office; four Commissioners will be deeply engaged and share ownership for overall Plan delivery; and an empowered, high-visibility Delivery Office will drive integration and coordination across agencies on a continuous basis.
- **Unprecedented public-private collaboration is critical to finally moving the needle on cost containment:** our aspiration is a health care transformation that is genuinely win-win-win, for payer, providers, and

consumers. We firmly believe that it is possible to reach a detailed end-state design in a truly collaborative way. Accordingly, we will establish formal payer and provider Steering Groups to help us finalize the most critical elements of Plan design, with clear decision rights and an effective, well facilitated engagement and decision making process.

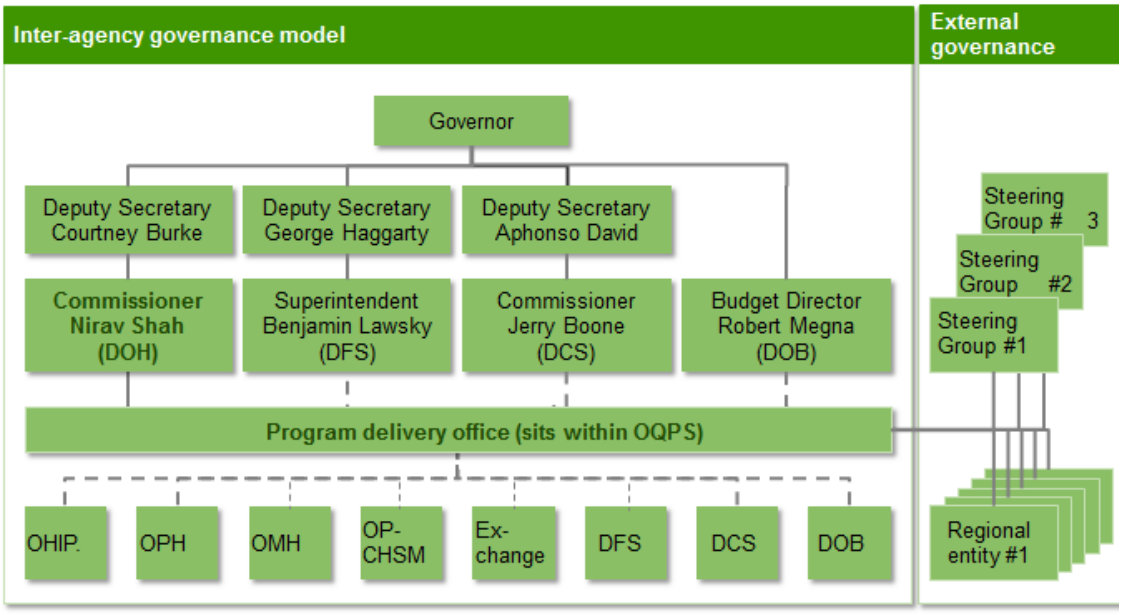
- **Although the Plan is established at the State-level, the bulk of implementation needs to be regional and local**: the 'ideal' balance of central versus regional or local design and delivery is a complex and delicate one, but one that we are committed to getting right. We believe we need to learn more from our key stakeholders before we understand precisely where to draw this line and are making this a priority during the detailed design phase. Once we have an agreed approach to regional/local design and delivery, we will work quickly to enable and support the infrastructure required.

1.2 OVERALL GOVERNANCE ARCHITECTURE

Our proposed overall governance model is described in Exhibit 25 below.

EXHIBIT 25: GOVERNANCE MODEL

The proposed governance model draws together NYS and external stakeholders, with a Program Delivery Office to drive integrated delivery



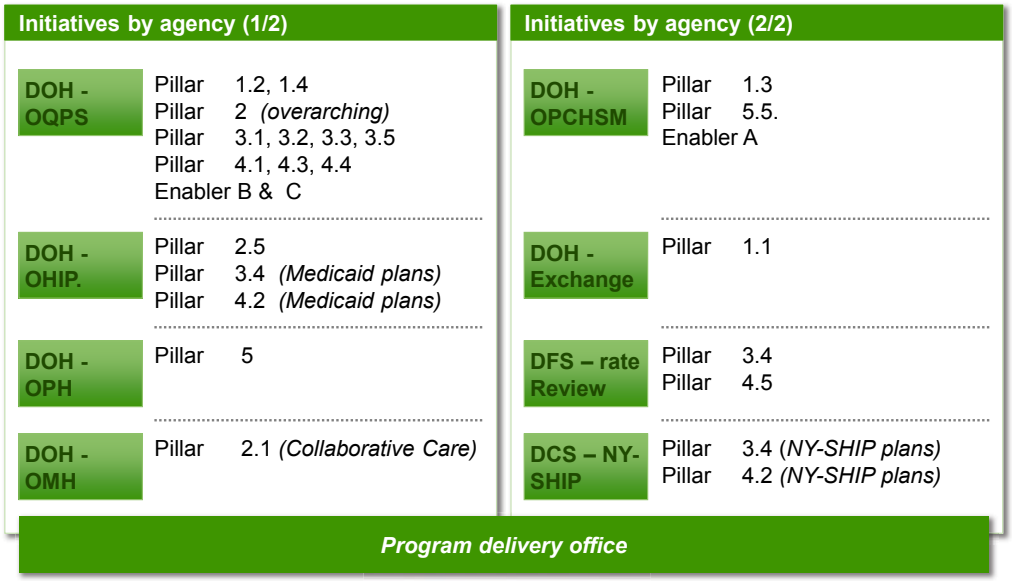
There are seven key features of the model to note:

- **Public-Private Partnership**: While the overall governance will be the responsibility of New York State it is clearly acknowledged that systemic transformation is a shared responsibility. The input, advice and collaboration of multiple state agencies together with consumers, providers and payers are critical to ultimate success of the Plan.
- **Governor-level sponsorship**: the State Health Innovation Plan is clearly a top-level State priority. Accordingly, it has sponsorship at the very highest level – the Governor's office. The relevant Deputy Secretaries will oversee the cross-agency collaboration across the three agencies and DOB.
- **Commissioner-level ownership across agencies**: while much of the activity required for Plan success resides within the remit of DOH, multiple other agencies all have critical roles to play – namely DFS (particularly in relation to the Rate Review process), DCS (particularly in relation to role modeling APC and VBID adoption using the State employee health insurance plan – the NY-SHIP), DOB (particularly in relation to ensuring ongoing financial sustainability of the effort, together with capture of the anticipated ROI) as well as the Offices of Mental Health and Alcoholism and Substance Abuse Services. Accordingly, the highest level of integration and cooperation will be required to deliver successfully. This will be best achieved if all relevant Commissioners share in line-level responsibility for Plan success. Practically, this means that macro-level Plan milestones will be built into the annual performance objectives of each Commissioner.
- **DOH Commissioner with overall accountability**: as noted above, the majority of activity required for successful Plan delivery resides naturally with the DOH. Accordingly, the Commissioner for DOH will take lead accountability for Plan delivery. Practically, this means that delivery of Plan milestones will form the major component of the Commissioner's annual performance objectives.
- **Agency and department-level accountability for specific initiatives**: the Plan comprises 38 separate initiatives. For clarity, and certainty of delivery, each of these initiatives has been delegated to an agency/department, responsible for on-time delivery. The draft allocation of these accountabilities is summarized in Exhibit 26 below.
- **Empowered program delivery office**: The Program Delivery Office will play a key role in driving both cross-agency collaboration, as well as collaboration with external stakeholders and steering groups. The Delivery Office will report directly to the Commission of DOH, but also have 'dotted line' accountability to the other three sponsoring commissioners. The role of the Delivery Office is described in further detail below.

- **Formal collaboration with external steering groups**: External partners will formally be integrated into the Plan delivery vehicle via the Program Delivery Office. Decision rights and accountabilities will be established in formal Charters, and the PDO will play the lead role in facilitating decision-making interactions and acting as a conduit for the effective flow of information from steering groups into the core NYS cross-agency delivery model.

EXHIBIT 26: INITIATIVE OWNERSHIP

The portfolio of SHIP initiatives have clear departmental ownership, with the program delivery office ensuring seamless cross-agency collaboration



1.3 OPTIMIZING PUBLIC-PRIVATE COLLABORATION

Although this State Health Innovation Plan sets out a comprehensive strategic blueprint for the transformation of health care delivery in NYS, there are still a number of detailed design decisions that must be resolved, within the strategic parameters that the Plan defines. The most critical of these relate to operationalization of the APC care delivery and payment model. These decisions must be made jointly with our private-sector collaborators, to ensure that the final model is truly a feasible, sustainable, win-win-win model that delivers to our full aspirations.

While not an exhaustive list, the following are the most critical design decisions that require detailed stakeholder input:

- Level of standardization of care coordination models, delivery infrastructure and funding
- Level of standardization of practice transformation models, delivery infrastructure, and funding
- Specific thresholds for APC recognition
- Level of standardization of payment models, and the role of the Rate Review process in recognizing and encouraging payer innovations with value-based payment models
- Level of standardization of metrics for evaluating APC performance

It is anticipated that some of these design elements will be standardized at a statewide level, while others will be at a regional level, a payer level, or fixed within individual payer-provider contracts. Resolving these important design decisions will be the priority of the stakeholder Steering Groups that will be established in the earliest phase of Plan delivery. At least four steering groups will be established: a Payer group, a Provider group, a Purchaser group and a Consumer/Consumer Advocate group. Opportunities for representation of all interested parties on all steering groups will be promoted. For example both payers and providers have shown interest in participating on workgroups that impact the APC model from the provider perspective and from the payer perspective.

Payer and provider groups will meet at least once every one to two months over the nine-month period and will be charged with aligning on the definition of the APC stages, eligibility criteria, evaluation metrics, the overall approach to and best practices for care coordination and practice transformation, payment models, and the approach to HIT requirements and support. All payers will be invited to join the Payer Steering Group, and participation is specifically anticipated from larger entities, including Aetna, Amerigroup, CDPHP, Emblem, Excellus, Fidelis, Healthfirst, HealthNow, Independent Health (of Buffalo), Metroplus, MVP Health Care, United, and Empire BCBS.[109] On the provider side, participation is specifically anticipated from American College of Physicians, Greater New York Hospital Association, Healthcare Association of New York State, Health and Hospitals Corporation, Medical Society of the State of New York, and New York State Nurses Association. Applications from other provider associations, physician groups, nursing associations, and academic medical centers are strongly encouraged.

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[109] Empire BlueCross BlueShield is the New York State subsidiary of WellPoint.

Purchaser groups will meet two-to-three times over the nine months and will be charged with aligning on any new approaches required for employer benefit design as well as for addressing any differences between fully insured and self-insured employers. We anticipate participation by the New England Business Group on Health (NEGBH); large purchasers including GE, Pfizer, Time Warner, Wegmans, and others; and large employee groups including New York City, New York State Health Insurance Program (NY-SHIP), and unions. Again, other applications will be strongly encouraged.

Consumer groups will meet three-to-four times over the nine months, likely in a town-hall setting with more frequent, informal opportunities for input (for example, website comments). This group will have a stake in designing the overall approach to care coordination and practice transformation, and will specifically discuss transparency and consumer-engagement initiatives.

1.4 INCORPORATING REGIONAL INPUT AND GOVERNANCE

As noted above, the specific approach to regional decision making and delivery remains a major outstanding design element, to be resolved in the early stages of detailed design, and in close collaboration with the Payer and Provider steering groups. Given this remaining design uncertainty, the specific approach to regional governance cannot yet be specified. However, the following principles will inform our approach to this issue:

- It is anticipated that regional entities will play a key role in delivery of practice transformation support, and care coordination services. They will also determine specific, local health priorities that may be reflected in APC metrics, and shape the development of community health registries and linkages.
- Once the role, scope and accountabilities of regional entities have been defined, it will be critical that they have appropriate access to funding, to ensure high quality and sustainable service delivery. To this end, the proposed RHIC model may provide a foundation for regional delivery, although it is noted that this model is not yet fully specified or funded.
- The State is committed to playing a lead role in enabling the emergence of regional entities that are effective, sustainable and truly fit-for-purpose for supporting Plan delivery, as agreed in collaboration with our key payer, provider and purchaser stakeholders.

1.5 ROLE OF THE PROGRAM DELIVERY OFFICE (PDO)

The PDO will play a fundamental role in driving successful delivery of the Plan, operating as the 'connective tissue' between the many different entities that need to come together efficiently and collaboratively in order to achieve the Plan's ambitious goals.

EXHIBIT 27: PROGRAM DELIVERY OFFICE ACTIVITIES AND DELIVERABLES

Specific objective	Deliverable
Support overall strategic design	1 Maintain cross-program view of key strategic issues and priorities
	2 Develop a quarterly 'refresh' of strategic approach in response to progress
Set up and run overall project management infrastructure	3 Develop charters with objectives, deliverables and timing, roles and responsibilities for each work-stream, in collaboration with work-stream owners or sponsors
	4 Map the overall program timeline across all work-streams, maintaining a clear view on the 'critical path', and proactively identifying and managing interdependencies across work-streams
	5 Manage overall delivery, including work-stream progress vs. timetable and risk register
	6 Provide short-term, targeted 'de-bottlenecking' support for work-streams when required
Coordinate overall stakeholder support and engagement	7 Develop and maintain a detailed stakeholder map
	8 Develop and periodically refresh the strategy for stakeholder engagement
	9 Develop formal charters and protocols for Steering Groups
	10 Prepare for and facilitate Steering Group meetings, and other stakeholder interactions
	11 Develop materials to support broader communication & education for all key stakeholder groups
Conduct program-wide research and analysis	12 Maintain a brief which summarizes key developments in health reform
	13 Share periodically new insights and research into best practices
	14 Conduct ad-hoc research as required to support critical program-level design decisions and preparation for key stakeholder interactions
Support program wide evaluation and reporting	15 Develop and manage the overall scorecard for measuring transformation and impact
	16 Assist in the design, measurement and communication of early-program / transitional reporting

2. Timeline and Milestones

NYS's objective for health care delivery transformation is to ensure that the process is predictable, transparent, and fair for all stakeholders who will be impacted by the changes. In order to achieve this objective, the process aims to be characterized by a high degree of upfront collaboration and stakeholder engagement, reasonable lead times ahead of major changes (to enable stakeholder readiness), and full transparency of the State's intention and actions at all times.

While delivery system transformation will be an ongoing priority, the State aims to achieve its three core objectives within five years, namely:

- 80 percent of the population cared for under a value-based financial arrangement
- 80 percent of the population receiving care within an APC setting, with a systematic focus on prevention and coordinated behavioral health care
- full transparency over the cost and quality of care at every step of the health care value chain, enabling informed choices by consumers and purchasers

2.1 HIGH-LEVEL TIMELINE

Over the next five years, these goals will be achieved in four key phases.

Phase 1: Detailed design (0–9 months)

Key deliverables will include:

1. **Creating and convening an internal governance structure**. Leadership, Planning Office, and working groups are described in the above "Governance" section.
2. **Delegating implementation ownership**. Ownership will be determined for each initiative depending on whether statewide leaders or regional systems are best suited to the tasks required. Initial views on the state-regional breakdown are laid out in the above "Governance" section.
3. **Organizing external stakeholders.** Larger, organized groups of external stakeholders will meet on a regular basis to provide input and come to consensus. These groups include payers, providers, purchasers, and consumers. Each stakeholder group will receive a case for change communication, detailing why transitioning to new care and payment models, supported by appropriately trained workforce and relevant HIT, will improve outcomes and costs. Details are laid out in the above "Governance" section.

4. **Determining eligibility and evaluation alignment**. In this period, we will determine specific **eligibility and evaluation criteria.** NY-SHIP and Medicaid will each need to determine requirements related to enrolling in their APC models, including any recognition process and use of existing infrastructure. The HIT working team will assist with this as needed. In addition, the evaluation working team will determine technical and operational requirements related to measurement.
5. **Addressing new regulation or legislation requirements**. At this time we will determine whether any new or altered regulation or legislation is needed and will develop drafts and make initial submissions of most new elements.

Pivotal milestones include:

1. **Approval of the Medicaid 1115 Waiver (expected),** which will potentially assist in funding for various components of APC
2. **Finalizing detailed design** of eligibility and evaluation criteria, workforce training, and any new incentives, regulation, and legislation
3. **Initializing operations** of the APC governance structure

At the end of phase 1, the State will have a comprehensive blueprint for system reform, with final decisions around all major design questions and an engaged and aligned set of stakeholders who have a shared vision for the future.

Phase 2: Implementation planning (9-to-18 months)

Key deliverables include:

1. **Continuing external stakeholder engagement**
2. **Identifying** vendors for practice transformation support
3. **Submitting** any remaining regulation, legislation, or policy
4. **Determining** necessary regional tailoring to APC design and implementation plan

Pivotal milestones include:

1. **Beginning discussions between payers and providers regarding which providers might qualify for APC**
2. **Regulating** minimum requirements for Rate Review approval
3. **Developing** standard reporting requirements for payers and providers
4. **Rolling out** the cost/quality transparency initiative, the patient portal, the APD, dial tone and member-facing services, and any EHR adoption incentives

5. **Launching** new workforce trainings and
6. **Implementing** Value Based Insurance Design products in NYS

By the end of phase 2, the State will have a fully operational APC system ready for launch, including finalized vendor procurement procedures, regulation/legislation, regional tailoring, and new HIT. All stakeholders will continue to be engaged through formal and informal structures.

Phase 3: Launch (18-to-30 months)

Key deliverables include:

1. **Generating progress reports to CMMI, payers, providers, and consumers**
2. **Using** evaluation takeaways to improve the APC model for the next years

Pivotal milestones include:

1. **The official launch of the APC model**
2. **The use of Rate Review and AHP process** to support APC adoption
3. **The launch of primary care practice transformation support**

A successful phase 3 involves a smooth launch of the APC program with approximately 35 to 40 percent enrolled as a result of effective stakeholder engagement and marketing and incentive schemes.

Phase 4: Scale-up (after 30 months)

Key deliverables include:

1. **Adjusting incentives and support in order to stay on target**
2. **Refining criteria** for the Rate Review and qualified health plan (QHP) process
3. **Evaluating** progress and impact, including reports to CMMI, payers, providers, and consumers

Pivotal milestones include:

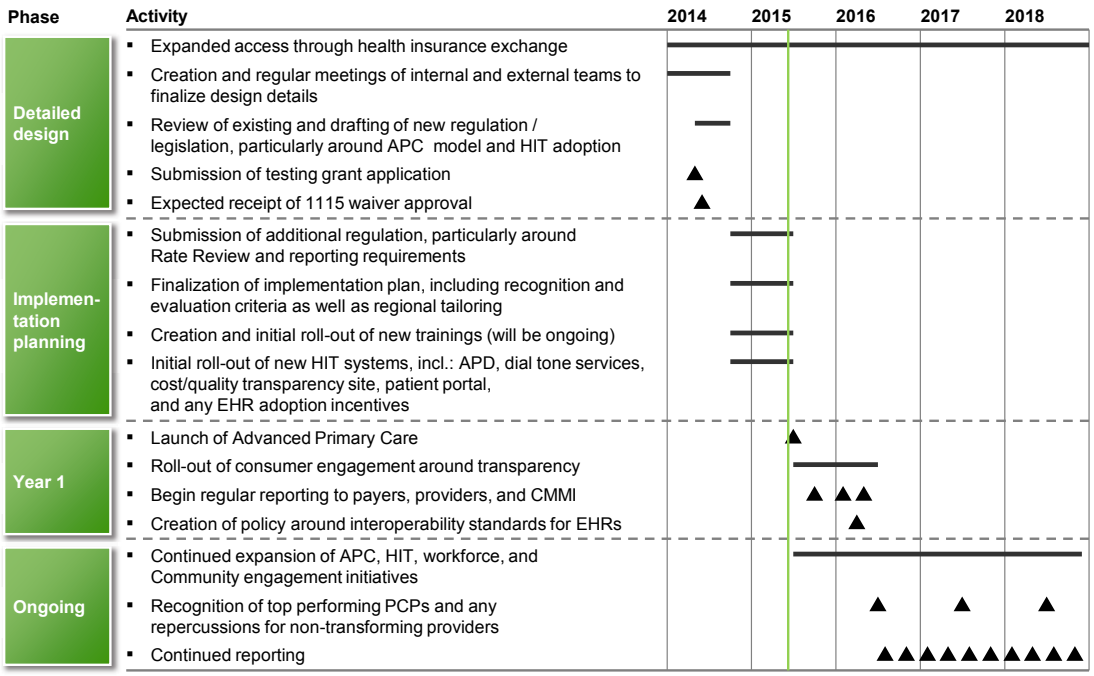
1. **Recognizing top-performing providers as well as financial repercussions for providers who fail to transform**
2. **Enrolling additional provider groups** with the goal of reaching 80 percent of the State's PCPs in five years

In phase 4, transformation efforts will continue to expand, with the goal of reaching 80 percent of consumers by the five-year mark. HIT rollout and adoption

will reach additional providers, and additional functionality will be added to the APD.

The above milestones are reflected in Exhibit 28 below, which depicts the major activities by phase over multiple years. New York will implement the majority of changes over a six-year time frame, including one year of upfront investment and planning in addition to the first five years post-launch.

EXHIBIT 28: APC IMPLEMENTATION PLAN



2.2 DETAILED MILESTONES ACROSS THE STRATEGIC PILLARS AND ENABLERS

EXHIBIT 29: APC MILESTONES

	Detailed design (Jan – Sep 2014)	Implementation planning (Oct 2014 – Jun 2015)	Year 1 (Jul 2015 – Jun 2016)	Ongoing (Jul 2016 onwards)
Access	▪ Refinements to Marketplace ▪ Coverage purchased through exchange becomes effective	▪ Federal funding for the exchange ends (January 2015)		
Integrated care	▪ Review existing legislation and regulation; begin necessary changes ▪ 1115 waiver approval to increase integration of care ▪ MRT, Prevention Agenda, and FIDA ongoing	▪ Advanced Primary Care confirmation of eligibility and program enrollment begins ▪ Regulate minimum requirements for Rate Review approval	▪ Launch of Advanced Primary care, increasing care coord. ▪ Behavioral health carve-in expected	▪ Continued rollout of APC, MRT, Prevention Agenda, FIDA, BH carve-in ▪ Recognition of top performing PCPs
Transpa-rency		▪ Roll out cost/quality transparency portal ▪ Roll out Patient Portal	▪ Market to consumers regarding cost/quality transparency Portal and Patient Portal	▪ Market to consumers regarding cost/quality transparency Portal and Patient Portal
Payment	▪ 1115 waiver approval to move Medicaid from FFS ▪ Potential development of specific VBID offering		▪ Launch of Advanced Primary care, introducing new payment models and moving away from FFS	▪ Financial repercussions begin for providers who fail to transform ▪ NYSHIP rollout of potential VBID offering
Community			▪ Practices proactive in community ▪ Creation and maintenance of community health organization registry website ▪ PCPs engaged in community resources for their populations	

	Detailed design (Jan – Set 2014)	Implementation planning (Oct 2014 – Jun 2015)	Year 1 (Jul 2015 – Jun 2016)	Ongoing (Jul 2016 onwards)
Workforce	▪ Increase/create training (team-based care, reporting on non-claims data) - trainings ready by Q3 2014 ▪ Monitor telehealth use ▪ Procure care coordination vendor(s) ▪ Procure practice transformation vendor(s)	▪ Continue trainings and workforce distribution correction	▪ Continue trainings and workforce distribution correction	▪ Continue trainings and workforce distribution correction
HIT	▪ Determine EHR adoption incentives ▪ Begin HIE adoption regulation/legislation	▪ Roll out All payer Database and dial tone services, continue expansion of HIE/EHR ▪ Begin implementation of EHR adoption incentives	▪ Interoperability standards for MU III ▪ Continually increase HIT system capabilities ▪ Continually increase HIT adoption	▪ Continually increase HIT system capabilities ▪ Continually increase HIT adoption
Program mgmt. and evaluation	▪ Form governance structure (leadership, core team, work-groups, external stakeholder grps ▪ Significant syndication across all stake-holder groups (including internal DOH/DFS/DCS, payers, providers, consumers, workgroups), including case for change communication ▪ Agree upon core set of metrics, evaluation scorecard, and parts of evaluation to be communicated to consumers	▪ Continue case for change communication/roadshow ▪ Create work plans in workgroups ▪ Define eligibility requirements for each APC stage and "NCQA Plus" and evaluation metrics ▪ Determine and plan for any necessary regional tailoring ▪ Begin CMMI quarterly reporting (after funding received) ▪ Hire eval. team ▪ Regulate standard reporting requirements for payers/providers	▪ Work, continue syndication as components evolve, hold regular meetings ▪ Begin measurement ▪ Begin quarterly or biannual reporting to payers and providers	▪ Work, continue syndication as components evolve, hold regular meetings ▪ Begin annual reports, publish annual reports ▪ Improve annual reporting over time

2.3 POLICY, REGULATORY, AND/OR LEGISLATIVE CHANGES

Three important regulatory levers will be employed to achieve the State's transformation objectives, namely:

- standard reporting requirements for payers and providers
- support of models that link payment with APC models of care
- requirements for payers to achieve rate-review approval (minimum penetration of value-based payment models and benefit design)

Additional policy, regulatory, and legislative levers will be necessary to enable new HIT initiatives, including:

- allowing consumers to access personal laboratory results from the HIE rather than from their own provider, if blanket permissions are insufficient
- allowing commercial claims data to be shared and analyzed over the APD, likely in the next year, as well as regulation allowing APD analytic output to include information only from providers who submitted full data
- requiring DOH-regulated providers with EHRs to connect to SHIN-NY, likely in the next year
- requiring Department of Education-regulated providers (mostly private providers) with EHRs to connect to SHIN-NY, likely to begin in the next year but which may require about three years to fully implement
- requiring policy that only interoperable EHRs can be connected to the HIE, likely within the next two years

A component of the planning phase will be to further investigate existing initial policies, regulations, and legislative measures to determine whether there are components that might present a challenge to the Plan, as well as potential novel efforts that would enable aspects of the Plan.

3. Financial Analysis

If New York State were to fully implement the Plan as described, by 2019 we would create $15 to 20 billion in value through reductions in waste and inefficiencies.

We estimate that 30-50 percent of these savings (or $6 to10 billion) may be reinvested in the delivery system in the form of care coordination fees, bonus payments, and/or shared savings payments that support improved access, consumer experience, and quality of care. We estimate an additional $1 to 2 billion investment through 2019 for provider transformation support, clinical workforce development, health information technology, program management and evaluation, and other costs.

After accounting for these investments, we project there would remain $5 to 10 billion in net savings over the five-year period from 2015-2019, with the potential to reduce the annual increase in health care spending by 1 to 2 percentage points by 2019. Beyond 2019, we estimate that net savings may exceed $5 billion per year; and health care cost trends may continue at 1 to 2 percentage points below what they would be otherwise without implementation of these changes, bringing health care spending growth closer to the real rate of growth in New York State's economy.

Our financial projections are based on these assumptions, which we further elaborate upon in the pages that follow:

- Baseline health care spending for New York State populations addressed by the APC model is projected to be $210 billion by 2019 before accounting for the impact of changes outlined in the Plan, based on ~3 percent projected annual growth in enrollment, and ~5 percent projected annual growth in health care spending per capita
- Pace of adoption of the APC model: By 2019, we expect that at least 80 percent of the population of New York State will be cared for by providers who meet criteria for either Standard APC or Premium APC, compared with an estimated 25 percent of the New York State population today
- Gross savings: Providers participating in APC and rewarded by shared savings payment models are projected to reduce health care spending by
- 6 to 12 percent over five years, consistent with examples of successful implementation of similar models in New York State and elsewhere
- Shared savings: 30 to 50 percent of gross savings are assumed to be reinvested in the delivery system in the form of care coordination fees, shared savings payments, or increased provider income under prospective payment models

Program investments in the design, implementation, and operation of new models and initiatives contemplated in the Plan are estimated at $1 to $2 billion through 2019, to be funded through a combination of grant funding, investments by payers and providers, and spending from state general revenues.

The analysis that follows is the summation of modeling of the potential economic impact for the major payer groups: Medicaid, Medicare, and Commercial. This methodology allows us to account for attributes unique to each payer population.

3.1 BASELINE HEALTHCARE SPENDING

In 2012, New York health care expenditures topped $150 billion and are expected to reach $170 billion for 2013; the average per capita health care expenditure in New York in 2012 was more than $8,300.

Below, we describe our projections for baseline spending without implementation of APC or other initiatives outlined in the Plan. Specifically, we have modeled future health care spending through 2019 for each of Medicaid, Medicare, and Commercial populations in order to account for differences in current costs, anticipated growth in enrollment, and projected increases in cost per capita. We have also excluded certain populations and expenses that are not directly addressed by the APC model.

Excluded Populations and Expenses

Our baseline estimates include costs for medical, pharmacy, and behavioral health care for the vast majority of New York's insured lives, including all those covered by NY-SHIP, all other self-funded and fully-insured commercial health plans, Medicare, and ~90 percent of Medicaid-covered lives.

We have isolated several populations and spending categories from our analysis that are either not directly addressed by the initiatives included in the Plan or have been accounted for in previous savings projections based on initiatives already in-flight.

- Dual Eligibles. Approximately 800,000 people in New York are eligible for both Medicare and Medicaid. They are among the most vulnerable and costly populations in New York State, with high costs of nearly $29,000 per beneficiary per year for Medicaid, and nearly $26,000 for Medicare. These numbers are roughly three times the average Medicaid cost per beneficiary and 80 percent higher than the average Medicare cost per beneficiary. Population numbers and medical expenses for duals are included in the Medicare segment, but have been excluded from Medicaid because Medicaid dual eligible expenses tend to be for services other than medical

care; non-medical expenses are not included in the impact analysis for the APC model.

- Other Special Needs Populations. Medicaid beneficiaries with special needs, including those with severe and persistent mental illness (SPMI), developmental disabilities (DD), and those who required long-term services and supports (LTSS) represent approximately 13 percent of Medicaid beneficiaries, including but not limited to those who have dual eligibility for Medicare and Medicaid as previously described. Medicaid has previously published independent investment and savings projections for these populations based on targeted initiatives including health homes, the FIDA demonstration, the behavioral health carve-in, and the managed Long-Term Care program. To avoid "double counting" of savings with those already projected based on these initiatives, we have excluded the 13 percent of Medicaid beneficiaries addressed by these initiatives, who comprise ~80 percent of Medicaid spending. Although our modeling does not include savings for the SPMI, DD, or LTSS populations, we do believe that the APC model supports improved medical care for these populations and will help to achieve goals previously set forth by the Medicaid Redesign Team.

- Uninsured. To be conservative, we do not explicitly include the health care costs associated with the uninsured population, anticipating that they may be more difficult to reach with the APC model, transparency initiatives, and many of the other cost-savings initiatives contemplated in the Plan.

- Costs for consumer liabilities. Our savings estimates include only reductions in spending by plans based on covered expenses, and do not include savings against consumer liabilities such as reduced spending on copays, deductibles, and co-insurance. We believe this exclusion is appropriate given that savings are expected to apply disproportionately to high-cost patients whose out-of-pocket costs will represent a small fraction of total costs. We anticipate some level of consumer out-of-pocket savings through increased cost transparency, which we expect to include savings for consumers with high out-of-pocket costs. However, we also anticipate that improvements in access to care arising from implementation of the Plan may actually increase consumer out-of-pocket spending for some healthy and low-risk patients.

Projected Growth in Cost per Beneficiary and Enrollment

We begin with costs per member per year (PMPY), which vary considerably across the three major payer types. In 2012, the average PMPY for the Medicare population in New York State (2.7 million) was approximately $14,000; for the Commercial payer population (9.4 million) it was approximately $8,100, and for the total Medicaid population (5.2 million) was approximately $9,600. After accounting for the exclusions of duals and other special needs populations as described, spending for the remaining Medicaid population (4.5 million) is estimated at $2,200 PMPY in 2012. As mentioned, this under-represents the total Medicaid costs that may be addressed by the Plan, but to keep estimates conservative, we have excluded populations and costs that have been factored into previous savings projections for health homes and other Medicaid initiatives.

With 2012 cost PMPY as a starting point, we factor in estimates from CMS and from the New York Department of Health (DOH) for enrollment and PMPY growth in order to project baseline spending out to 2019 (Exhibit 26). We estimate that enrollment in Medicaid and in commercial plans grows between 1.5 and 2 percent per year. We estimate that the Medicare population will grow faster, at 3 percent per year, as the wave of "baby-boomers" ages. PMPY growth rates are estimated at 3 to 5 percent for the next five years.

If nothing is done to bend the cost curve, by 2019 New York health care spending could well exceed $210 billion, after applying the aforementioned exclusions, which is approximately a 50 percent increase over estimated 2014 spending of $140 billion.

3.2 PACE OF ADOPTION

In order to achieve our goal to have 80 percent of the State population cared for under the APC model, we will need to achieve 90 percent adoption among payers (weighted by membership); with 90 percent of primary care providers achieving either Standard or Premium APC status, whether independent, employed, or otherwise affiliated with integrated delivery systems, medical group practices, independent practice associations (IPAs), or other organizational models.

3.2.1 Payer Participation

Our savings projections are based on the assumption that, over the coming five years, substantially all Medicare, Medicaid, and commercial insurers in New York State will participate in the APC model, including adoption of common performance measures, co-funding of practice transformation support, and payment of providers through care coordination fees and/or outcomes-based payments. These outcomes-based payments include pay-for-performance as well as different forms of shared savings models, such as gain sharing, risk sharing,

and/or capitation. These ambitious goals for payer participation are based on several factors.

- The State is committed to full participation of both Medicaid as well as NY – SHIP, New York's health insurance plan for state employees.
- Our Plan has received a uniformly positive response and constructive input from the leading payers operating in New York State, as well as the leading payer industry associations. In addition, most payers participating in the state are already supporting similar initiatives, and many have had success in multi-payer initiatives within the state as described earlier in our Plan.
- The APC model is consistent with medical home initiatives that have received strong support from a number of self-insured employers as well as some of the largest and most influential labor unions in New York State.
- The APC model and other initiatives described in the Plan are consistent with models being supported by Medicare, including the Comprehensive Primary Care initiative as well as the Medicare Shared Savings Program.

3.2.2 Provider Participation

We aspire that by 2015 as many as 40 percent of primary care physicians (PCPs) will actively participate in the APC model, and be eligible for care coordination fees, and pay-for-performance, and/or shared savings payments. This would include both independent PCPs as well as those employed by hospitals or large medical groups, as well as PCPs participating in IPAs, Accountable Care Organizations, or other clinically-integrated networks.

We aspire that by 2019, 75 percent of PCPs will be prepared to accept accountability for total cost of care through gain sharing, risk sharing, or capitation models, with an additional 15 percent expected to remain in pay-for-performance models. Again, this includes independent, employed, and system-affiliated PCPs.

3.2.3 Percent of Population in APC model

Based on our goals for payer and provider adoption, we believe that approximately 25 percent of New York lives will be enrolled in an APC model with a value-based payment arrangement in 2015. Over the next four years, we believe—building on current market trends in the capabilities that practices are developing—that targeted HIT initiatives and practice transformation support programs will ensure that 80 percent of lives are enrolled in APC with a value-based payment arrangement by 2019.

3.3 GROSS IMPACT BEFORE INVESTMENTS

Through the implementation of APC, we expect a system wide reduction in emergency room visits and avoidable hospital admissions, the substitution of lower cost therapies including generic pharmaceuticals, and a shift to specialists who deliver value through high quality at lower costs. Examination of similar models implemented in New York State and other parts of the U.S. suggests that waste elimination can lead to a 6 to12 percent reduction in overall health care costs over a five-year span.

For purposes of our financial modeling, we have assumed this 6 to 12 percent reduction in spending for providers participating in total cost of care gain sharing, risk sharing, and/or gain sharing arrangements. For the providers who are not prepared to take on accountability for total cost of care and elect instead a more moderate pay-for-performance model with lower performance requirements, we assume approximately one third the impact over five years (2 to 4 percent vs. 6 to 12 percent). In practice, the relative impact of these different models will depend on the level of incentives, the rigor of performance measurement, and the effectiveness of implementation.

In light of our assumptions for increasing adoption through 2019, and allowing five years for participating providers to achieve our target of 6 to12 percent reduction in costs, we project that the Plan would break even by 2016 (if fully implemented at the pace outlined), and that by 2019 annual savings would be approximately $9 billion before accounting for provider incentives and other investments, to be described below.

Our modeling projects differential savings by payer type based on a number of payer-specific dimensions: current PMPY costs; future PMPY cost trends; number of covered lives in the State; and payer participation expectations (where we presume that public payers including Medicaid, NY-SHIP, and Medicare will lead the way with participation, and that commercial payers will follow suit). For instance, based on these dimensions, we estimate that the 2019 potential annual savings of approximately $9 billion would be composed of approximately $2 billion in savings for Medicaid and NY-SHIP, up to $3 billion in savings for Medicare; and up to $3 to 4 billion in savings for commercial plans (across both fully insured and self-insured populations).

In light of the timeframe allowed for implementation of the initiatives, the level of impact from reductions in waste and inefficiency would continue to grow until the APC model reaches maturity in 2022.

Longer-term, we believe that the APC model and other initiatives described in the Plan will continue to put downward pressure on the health care cost trend in two ways:

- The first is through an increased focus on prevention. Integrated care delivery complements priority focus areas of New York's Prevention Agenda: prevent Chronic Disease; promote healthy women, infants and children; promote mental health and prevent substance abuse; create healthy environments; and prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and health care-associated infections. Enrollment in APC and subsequent evaluation will require that providers report on metrics such as comprehensive diabetes screening, counseling and prenatal care, depression screening, and HIV infection rates. Additionally, providers are motivated to focus on prevention above and beyond what is prescribed in their evaluation metrics because it is a relatively resource-light method of keeping a patient's total cost of care low.

- Second, the new care delivery system fundamentally changes the economics of the health care system. With fewer fee-for-service arrangements, we assume that yearly rate increases that are not linked to performance may trend toward general inflation, so that increases above inflation are largely tied to quality and efficiency.

Taken in combination, we project that in five to 10 years, the downward pressure applied by the initiatives outlined in the Plan may sustain a 1 to 2 percent reduction in health care costs even after providers have achieved the 6 to 12 percent decline in spending attributable to one-time reductions in waste and inefficiency. We also consider the possibility that providers may eliminate waste and inefficiency comprising more than 6 to12 percent over the long-term, in light of research by the Institute of Medicine and other organizations that have estimated total avoidable healthcare spending at close to 30 percent.

3.4 DELIVERY SYSTEM RE-INVESTMENT

We anticipate that investments in the delivery system will be necessary to bring about the changes outlined in the plan, and that they may come in multiple forms: (1) upfront investments in new capabilities, paid in the form of care coordination fees, enhancements to fee schedules, and/or payments for new services not previously reimbursed; (2) bonus payments tied to quality and efficiency; and (3) shared savings payments based on quality and reductions in health care spending and/or growth in spending.

These payments will need to be sufficient to both offset provider investments in new capabilities as well as reduced productivity in terms of frequency of patient visits as providers shift resources toward services not previously reimbursed. The potential upside will also need to be sufficient to create a compelling return on investment for providers.

Based on our examination of value-based payment arrangements in New York State and other markets, we have assumed that 30 to 50 percent of the value to be created through the Plan will be reinvested in the delivery system in the form of upfront investments, bonus payments, and/or shared savings payments. We anticipate that the choice of whether to offer these payments, in what proportion and at what rate, will be determined independently by each payer. Our estimate of 30 to 50 percent of gross savings reflects an interim assumption strictly for purposes of modeling the potential financial impact of the initiatives outlined in the Plan.

For purposes of our financial modeling, we assume that care coordination fees will be paid directly by payers and represent an offset to savings. For planning purposes, we have assumed that care coordination fees or other upfront investments represent 0.5 to 2 percent of total cost of care for in-scope populations, with higher levels of payment for populations for whom chronic disease represents a greater proportion of spending. We assume that care coordination fees will break even by the second year for participating providers.

Gain sharing is the percentage of savings that is "paid-back" to the providers and is one of the key economic incentives for providers to participate in value-based payment models. We believe that the balance of upfront payer investments and retrospective gain-sharing will likely differ across payer types and provider contracts. Hospital-based providers will likely demand the highest level of gain sharing for commercial contracts in light of foregone revenue associated with reductions in hospital volume. We expect lower gain sharing distributions will be more practical for Medicare and Medicaid, and for physician-led organizations.

For purposes of calculating gain sharing, we have assumed that baseline costs are recalculated on average every two years, or using a three-year baseline weighted 60/30/10%, which is consistent with payment models implemented in other markets. We anticipate that the duration of the baseline may be determined independently by each payer unless multi-payer data aggregation dictates otherwise.

3.5 PROGRAM INVESTMENTS

Achieving the cost savings outlined above will not only require sustained and visible leadership from the Governor and the DOH, DFS, DCS, and DOB, but also a considerable, coordinated upfront investment. We believe that investing $0.8 billion over five years, across all payers, will be necessary to achieve the successful implementation of the APC model. It will primarily support HIT, practice transformation grants, and program management and evaluation. This $0.8 billion is incremental to the $500 million for Workforce development already requested as part of the Medicaid 1115 waiver currently pending; and the $200

million in funding for HIT for which HCRA and other funding sources are currently being contemplated. The broader multi-year plan to finance the Plan has not been finalized, but we are in an active process to consider multiple options.

The total fixed investment in years 0-5 represents less than 1 percent of system spend and quickly falls to below 0.5 percent of system spend on an ongoing basis.

In the APC model, we expect that the primary upfront investment cost incurred to providers will be in the categories of HIT, practice transformation, and primary care workforce improvements. HIT spending is expected to include increased EHR and HIE adoption. Investments in practice transformation may include but are not limited to resourcing expertise to facilitate skills, and operational and organizational improvement to achieve APC standards. Finally, primary care workforce improvements will be necessary. Funds will be needed for hiring and training the necessary staff, especially those with specific expertise, such as care coordinators. For Standard APC practices, practice transformation and care coordination financial support will offset many of these practice-based investments. Practice transformation investments are modeled at an average of $24,000 per practice, which is equivalent to an average rate of slightly less than $1 PMPY. However, we do anticipate that primary care practices will determine and fund HIT investments appropriate to their needs. A more detailed budget is located in the "Budget" section of this document.

3.6 NET SAVINGS

We believe that the Plan not only has the potential to deliver improved health, quality of care and patient experience, but also to reduce the cost trend by 1 to 2 percentage points and to generate nearly $17 billion in gross value creation over five years. This large economic return is calculated as the difference between projected spending without implementation of the Plan, as discussed above, and estimated spending as a result of savings produced by the complete set of SHIP initiatives.

Of the $15 to $20 billion saved through successful execution of the Plan, we estimate that about half will either be reinvested in providers in the form of shared savings and care coordination financial support, as well as upfront investments for HIT and practice transformation support. The remaining $5 to $10 billion accrues to the system as net savings.

These cost savings are not spread equally over the five years. Because of upfront investments and a target launch date of the first quarter of 2015, there is a total system investment of almost $1 billion from 2014-2016, of which roughly $270 million is incremental (not already requested). However, when net savings turn positive in 2017, they total approximately $1.1 billion. In addition, once the

positive net savings begin to accrue, they do so non-linearly, from $1.1 billion in 2017 to $2.9 billion in 2018 and $5.5 billion in 2019.

Our expectation is that the net savings, if achieved on a multi-payer basis, will lead to improved affordability of health care in the form lower-than-otherwise-anticipated increases in health insurance premiums, and cost increases to the Medicaid and Medicare programs. Of course, actual increases in premiums will also continue to depend in part on the level of competition among health plans as well as regulatory oversight of premium increases.

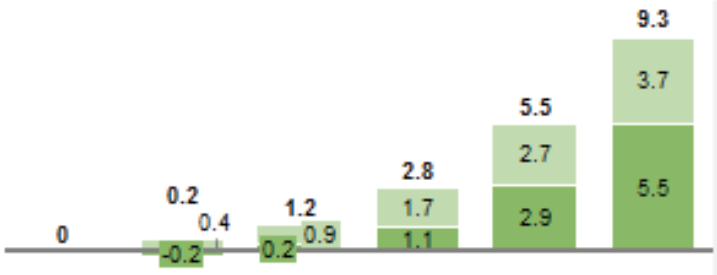
EXHIBIT 26: EXPECTED ROI AND NET SAVINGS

PRELIMINARY DRAFT

The Plan will yield an estimated incremental 6x ROI of $9.5B in net savings in addition to a $9.5B reinvestment in providers

Potential financial impact

$ billions



SFY April...	2014	2015	2016	2017	2018	2019	Total system
Total Investments	(0.3)	(0.3)	(0.3)	(0.3)	(0.1)	(0.1)	~1.5
Incremental Investments	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	~0.8
Net savings[1]	(~0.1)	(~0.4)	~0.1	~0.9	~2.7	~5.4	~8.7

*Includes care coordination payments, bonus payments, and shared savings tied to quality, experience, and efficiency

3.7 EXISTING INITIATIVES

Through implementation of the Medicaid global spending cap, the State has already created the framework and foundation for capturing many billions of dollars of savings in Medicaid spend over the coming years. The existing portfolio of initiatives developed by the Medicaid Redesign Team (MRT) represents the first wave of improvement efforts to help achieve the bold spending cap target

immediately and for the near future. These initiatives primarily target special populations that have been excluded from this analysis, and safety-net hospital providers.

For example, the current integration of health homes is an example of MRT initiated innovation designed to reduce and control utilization of inpatient care while simultaneously improving health and care quality. Indeed, health homes integrate into existing managed care provider networks to connect patients with community-based organizations so that both social and medical needs are addressed.

New York's Medicaid waiver application also features innovative value-based payment models and care delivery systems including the Fully Integrated Duals Advantage (FIDA) demonstration, Delivery System Reform Incentive Payments (DSRIP) and the behavioral health carve-in. For instance, FIDA's approach to managed care is designed to improve care for New York's costliest and most complex patient population. The FIDA demonstration fully integrates all Medicare and Medicaid physical health care, behavioral healthcare, and long-term support and services.

In contrast to existing MRT initiatives, the APC model targets the 'general population' (i.e. non special needs), and focuses on the primary care sector (as opposed to hospitals and more specialized care providers, that are a bigger focus of current MRT initiatives. The APC model will form a critical complement to existing Medicaid initiatives, providing an important enabler for ongoing achievement of the global cap.

3.8 BREAKEVEN AND RETURN ON INVESTMENT

Economically, the APC model is self-sustaining. Just three years after launch, net savings to the system are positive, with the "break even" point on cumulative investments occurring between years three and four.

Moreover, the upfront investment required is less than 1 percent of total healthcare spend. There are several potential sources of funding, including federal grants (including the State Innovation Models Testing Grant for which the funding opportunity announcement is anticipated in early 2014), the federal match as it relates to Medicaid investments, and the State's ability to allocate state funds to the program or to promote investments that are aligned with the APC model of care. After five years, we expect ongoing investment expenditures to taper to under 0.2 percent of the total cost of care. Supplementary payments to providers will continue, including from NY-SHIP, Medicaid, and other payers, but our modeling assumes that these payments will only be scaled and continued to the extent that they are fully offset by savings to the system.

V. Appendices

Appendix A. Existing Programs and Waivers

A.1 MEDICAID AND DOH PROGRAMS AND WAIVERS

A.1.1 Medicaid Redesign Team (MRT)

In 2011, Governor Cuomo convened a group of Medicaid and other health delivery system stakeholders to identify key concerns with the program and suggest solutions. They found that Medicaid has been decreasing in value: increasing costs but unchanged outcomes. A first phase of the redesign provided a blueprint for lowering Medicaid spending by $2.2 billion in SFY 2011–12. It provided 78 recommendations, including a global spending cap for DOH-controlled programs, which assigned the DOH commissioner increased ability to implement cost-saving controls if spending exceeded the new benchmark. A second phase of the redesign is developing a longer-term action plan to reform the Medicaid program. This phase includes more than 124 projects, most of which are currently in progress.

In all, the redesign includes five key components: 1) case management for all, 2) advancement of health homes, 3) universal access to high quality primary care, 4) the global spending cap, and 5) targeting the social determinants of health. In order to fully transform Medicaid, the redesign seeks to eliminate fee-for-service (FFS) payments and move toward risk sharing / capitation. In addition, the redesign hopes to work toward a fully integrated delivery system by coordinating all medical, behavioral, and long-term-care services into a system of comprehensive care. Fully integrating the delivery system involves continuing and enhancing existing programs, including continuing PCMH incentive payments to recruit and retain PCPs, a completion of ambulatory care physical infrastructure, and an expansion of health home providers to address special needs and complex care recipients.

The Medicaid Redesign Team (MRT) is also focusing on key enablers to Medicaid transformation, including workforce and HIT. It is coordinating and funding training of clinical and nonclinical workers to manage chronic diseases, coordinate care, and integrate medical, behavioral, and long-term-care services as well as allowing midlevel providers to address workforce flexibility and scope of practice to ensure that each type of health worker is working at the top of his or her license.

Additionally, the MRT is expanding the categories of providers eligible for HIT assistance, including behavioral and long-term-care providers.[110]

110 http://www.health.ny.gov/health_care/medicaid/redesign.

A.1.2 MRT 1115 waivers

New York is seeking a five-year waiver amendment to fundamentally restructure the State health care delivery system by building on progress already underway from the state's MRT. As a central component of MRT going forward, the proposed MRT DSRIP plan will reinvest federal savings already produced by MRT initiatives into a series of critically needed performance capacities and delivery system reforms to further achieve the Triple Aim. The ultimate goal of this plan is to reduce avoidable hospital use by 25 percent.

New York's DSRIP plan is focused on reducing avoidable hospital use. While there are multiple avoidable hospital use measures, New York proposes to build off existing performance metrics used in its Medicaid managed care program as well as the New York State Health Innovation Plan. Specifically, New York proposes to the use the four following nationally recognized measures for avoidable hospital use:

- Potentially Preventable Emergency Room Visits (PPVs): are a set of measures that identify emergency room visits that could have been avoided with adequate ambulatory care.
- Potentially Preventable Readmissions (PPRs): are a set of measures for readmissions to a hospital that follows a prior discharge from a hospital and that is clinically-related to the prior hospital admission.
- Prevention Quality Indicators – Adult (PQIs): are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs are population-based and can be adjusted for covariates for comparison purposes.
- Prevention Quality Indicators – Pediatric (PDIs): are a set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level. Similarly the PDIs are population based and can be also be adjusted for covariates for evaluation.

In sum, these measures reflect a comprehensive view of avoidable hospital use. The baseline for evaluation will be actual 2011 Medicaid results. Performance will focus on all Medicaid members, including the dually-eligible population, which meet the criteria for inclusion for each measure. The five-year goal is to reduce each measure by 25 percent. The state expects to be at least 50 percent of the way to the 25 percent reduction mark by the waiver's third year. These initiatives,

targeted to the Medicaid population will support, leverage and better assure ultimate success of the SHIP.

A.1.3 Other Federal Medicaid Waivers

In addition to the requested 1115 Waiver, a number of existing waivers are driving other aspects of Medicaid improvement that are related to MRT goals. These waivers will allow spending beyond existing Medicaid restrictions with the intention of improving outcomes and realizing savings in services, especially in institutional care.[111]

- 1915b.c waivers allow Medicaid to extend capitation and cover case management and community services as well as support coordination of care.
- New York Federal State Health Partnership (F-SHRP) provides federal financial support to a reform program that addresses the State's need to modernize acute and LTC infrastructure, increase capacity in primary and ambulatory care, and invest in HIT. Further, it allows the State to enroll certain Medicaid populations into managed care on a mandatory basis. When F-SHRP ends in 2014, some of its State match may be redirected to the pending MRT 1115 waiver.
- The NYS Office of Mental Retardation and Developmental Disabilities Care At Home IV (OMRDD-CAHIV) waiver provides case management, respite, and assistive technology for individuals with Mental Retardation and Developmental Disabilities (MR/DD) and autism in those individuals under age 17.
- The NY Care at Home I/II waiver provides case management, bereavement services, expressive therapies, family palliative care education (training), home and vehicle modifications, massage therapy, pain and symptom management, and respite for the physically disabled in individuals under age 17.
- The NY Traumatic Brain Injury waiver provides service coordination, assistive technology, community integration counseling, community transitional services, environmental modifications, home and community support, independent living skills and training, positive behavioral interventions and support, respite, structured day programs, substance abuse programs, and transportation for aged and disabled patients over 18 years of age with brain injuries.
- The Office of Mental Health Seriously Emotionally Disturbed (NY OHM SED) waiver provides for crisis response, family support, individualized care

[111] Medicaid.gov:Waivers.

coordinators (case management), intensive in-home care, respite, and skill building for individuals ages 5–21 with severe, emotional disorders.

A.1.4 NYS Public Health Prevention Agenda

The Prevention Agenda 2013–2017 spans a five-year time frame. It establishes five goals: improve population health status, look for health implications in social policies, strengthen public–private partnerships to achieve public health improvement at the State and local level, direct new public health investment at controlling health care costs, and increase economic productivity. Five priority areas are designated: preventing chronic disease; promoting safe and healthy environments; promoting the health of women, infants and children, expanding mental health and substance abuse treatment, and reducing the spread of HIV, sexually-transmitted diseases, vaccine-preventable diseases and health care-associated infections. Statewide public health and local plan development is aligned with a broad array of state, industry, and regional stakeholders. Examples of action items undertaken in support of the Agenda include the development of work plans for each priority area, establishment of a protocol for annual tracking of the 58 Prevention Agenda objectives, and provision of community guidance to local health departments on how to implement the Agenda.

A.1.5 Community, Opportunity and Re-Investment (CORe) initiative

In 2012, Governor Cuomo launched the Community, Opportunity, and Re-Investment (CORe) initiative with the intent of increasing the well-being of communities and ensuring that all inhabitants are able to grow and thrive in supportive, safe, and stable communities.[112] This initiative was formed because of inconsistent outcomes related to costly investments within needy neighborhoods. CORe intends to:

- Identify neighborhoods with the greatest social and economic needs
- Help neighborhoods identify quantifiable goals related to quality of life improvements and ways of measuring impact
- Improve alignment between public and private resources to support successful community-based interventions
- Develop strategies that are customized to meet local challenges
- Build partnerships between public and private, city and neighborhood-level organizations to develop solutions

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[112] New York Association of Psychiatric Rehabilitation Services, Inc. NYS Community, Opportunity, & Reinvestment Initiative Seeks Interested Groups, October 10, 2012.

- Support communities that exhibit readiness to partner across sectors and respond to these strategic approaches

One organization in each city will work with New York State to lead the development of strategies across sectors.

CORe has the following goals:

- Reduce crime, creating a safer environment
- Address poverty through support for education and employment opportunities
- Produce and support a skilled workforce that has access to jobs
- Strengthen social bonds
- Improve health at every age
- Improve educational outcomes
- Ensure equal access to necessary services to eliminate outcome disparities
- Ensure access to safe and affordable housing

A.1.6 New York's Health Home Medicaid Service

Section 2703 of ACA defines the health home as an optional Medicaid service that states may request via a State Plan Amendment, which NYS has done. Medicaid health home (HH) eligibles must have either two chronic conditions, one chronic condition and risk for another, or a serious and persistent mental health condition. A health home is a care management service model whereby one care manager coordinates communication between all of an individual's caregivers so that all patient needs are addressed in a comprehensive manner. Each HH "network" is required to include a broad range of mandatory provider capacities, including medical, behavioral health care, HIV, housing, and wrap-around services, all integrated with HIT. A provider can bill Medicaid only for a month in which one of the five of these services is provided. New York's average per member per month (PMPM) for HH is $209 downstate and $174 upstate, but varies based on severity of illness and mental health status.[113]

A.1.7 New York's Behavioral Health Managed Care

Behavioral Health Managed Care Design (BHMC) is a Phase 2 product of the MRT Behavioral Workgroup and supports fully integrated treatment where behavioral and physical health are valued equally and patients' recovery goals are supported through a comprehensive and accessible service system.

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[113] www.health.ny.gov/health_care/Medicaid/program//medicaid_health_homes.

Individuals with severe behavioral health needs will have their care managed by Health and Recovery Plans (HARPs), which will provide an enhanced managed care benefit package with financial management services; crisis respite; community, peer, and family supports through financial or other incentives; and rehab supports including employment and education. Additional benefits will include existing mental health State plan services, for example, Inpatient Mental Health, Clinic, Personalized Recovery Oriented Services, Partial Hospitalization, opioid treatment, outpatient chemical dependency, rehabilitation, and rehab supports in community residences.

Individuals with less severe but qualifying conditions will have their care managed by mainstream Managed Care plans. Those plans that do not meet rigorous behavioral health (BH) standards must partner with a Behavioral Health Organization to provide the full suite of services.

Eligibles' membership will be determined by the State using prior utilization data, open enrollment from the Medicaid population, and additional assessments in development. Performance metrics specific to BH outcomes and plan management will need to be developed. [114]

A.1.8 Fully Integrated Duals Advantage (FIDA)

New York's CMS approved FIDA pilot seeks to implement a fully capitated payment model for 170,000 of its 700,000 dual eligibles. This population will be automatically enrolled, but may opt out. Those eligible include individuals requiring more than 120 days of long-term service and support (LTSS), eligible for the nursing home diversion program, and certain individuals eligible for, or in receipt of, institutional long-term-care services in eight downstate counties. Such individuals in upstate counties will receive similar care from New York's Medicaid health home program. New York's FIDA proposal builds on an existing program, Medicaid Advantage Plus (MAP), which integrates Medicare acute and Medicaid long-term-care services into a capitated plan. This program has 3,000 members, all of whom will be automatically enrolled in FIDA. The Program of All-Inclusive Care for the Elderly (PACE) provides a similar benefit structure and includes 5,000 members, but those recipients will be excluded from FIDA. Another 58,000 MA recipients in partial MLTC capitation are likely to transition to FIDA. (source: www.medicaidinstitute.org/ assets/1052).

The benefit package includes all Medicare and Medicaid and a number of waiver services. Care coordination will be based on an Interdisciplinary Care Team (care manager, primary care physician, BH professional, home care aide, and other

[114] www.health.ny.gov/health_care/Medicaid/Redesign/Behavioral_Health_Reform.htm.

essential providers). Beneficiaries will have no costs for services. An external evaluator will measure quality of care and be responsible for the existing reporting in the State's 1915 and 1115 waivers and other agreed-upon monitoring measures. Rates will be blended using NYS and Medicare data and methods and to reflect increasing discounts (savings) over the first three years. A capped medical loss ratio will be used and quality withholds for performance based on certain quality measures.[115]

A.1.9 PCMH Incentive Program (MA)

State Law (Article 5, Title 11) passed in 2010 authorized the DOH commissioner to establish a statewide patient-centered medical home (PCMH) incentive program for providers with NCQA PCMH certification. The program is available to both capitated and FFS Medicaid providers who meet NCQA standards using the health home approach to service delivery and coordination. New York Medicaid has 13,000 enrolled primary care providers. As of March 2013, 4,472 were certified PCMH providers. Of these, 83 percent were certified at Level 3 and most of these 83 percent were certified based on the less stringent 2008 NCQA standards. PMPM payments are made to providers commensurate with their NCQA certification level (Level 1: $2; Level 2: $4; Level 3: $6). One-and-a-half million Medicaid Managed Care and Child Health Plus enrollees and 84,000 FFS enrollees were assigned to a PCMH provider in 2012.[116]

A.1.10 Health Care Innovation Awards

The Health Care Innovation Awards provide up to $1 billion in awards to organizations that are implementing the most compelling new ideas to deliver the Triple Aim to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP). Of the 13 projects that include facilities in New York, four are located entirely in New York State:[117]

- **Finger Lakes Health Systems Agency** was awarded a $26.6 million, three-year grant by CMMI to transform health care in the Finger Lakes region

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115 http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/dual_demo_proposal_to._cms.htm. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf.

116 http://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_initiative.pdf, http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-12spec.htm, http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm.

117 CMS.gov: Health Care Innovation Awards: New York http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/New-York.html.

- **The Bronx Regional Health Information Organization** will develop data registries and predictive systems to better integrate care and reduce the cost of care for Medicare and Medicaid patients.
- **The Fund for Public Health in New York** will work with NYC Department of Health and Mental Hygiene's Division of Mental Hygiene to implement Parachute NYC, a needs-adapted treatment model for Medicaid and psychosis patients in Manhattan, Queens, Brooklyn, and the Bronx.
- **Maimonides Medical Center** aims to better coordinate care and services by improving communication between providers and monitoring of patients though advanced health information technology tools in Brooklyn. It expects to reduce psychiatric and medical hospital admissions by 30 percent.
- **University Emergency Medical Services** targets 2,300 Medicare and Medicaid beneficiaries who have had two or more ED visits over the last year at two hospitals in Buffalo, NY. The project places community health workers in emergency departments and links patients to primary care, social and health services, education, and health coaching. Cost savings are estimated to be $6.1 million.

A.1.11 Medicaid Incentives for Prevention of Chronic Disease in Medicaid Demonstration

New York is one of 10 states to be awarded Medicaid prevention grants, receiving $2,000 in the first year. The New York State Medicaid Incentives Plan pilots interventions focusing on quitting smoking, lowering high blood pressure, and managing or preventing diabetes. It will provide direct cash payments or lottery tickets as incentives. Participants will be assigned to 1 of 4 treatment arms: 1. Receive incentives for process activities (i.e. participating in smoking cessation counseling or attending primary care appointments), 2. Receive incentives for outcomes (i.e. rewards for quitting smoking or maintaining reduced weight), 3. Receive incentives for both process activities and outcomes, 4. Receive no incentives (control). The program aims to enroll 18,000 Medicaid beneficiaries from throughout the state.[118]

A.1.12 Innovation Advisors Program

The Innovation Advisors Program is designed to engage health care leaders to drive delivery system reform to benefit Medicare, Medicaid, and CHIP

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[118] CMS.gov: Medicaid Incentives for Prevention of Chronic Diseases Grants Fact Sheet http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4114&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=0&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=1&year=2011&desc=false&cboOrder=date.

beneficiaries. The program will support selected "Innovation Advisors" to expand their knowledge in the areas of health care finance, population health, systems analysis, and operations research. Innovation Advisors will then bring their enhanced knowledge and skills back to their home organizations in pursuit of the Triple Aim and develop and support new ideas for care delivery pilots. Total program cost of $5.9 million will support training for the Innovation Advisors and provide stipends for their home organization or group.

CMS announced 72 Innovation Advisors in January 2012 from 27 states. Seven of the selected health care professionals are from New York State, mostly from the greater New York City area.[119]

A.1.13 Strong Start for Mothers and Newborns Initiative

The Strong Start for Mothers and Newborns initiative hopes to reduce preterm births and improve outcomes for newborns and pregnant women using two strategies:

- Public-private partnership and awareness campaign to reduce the rate of early elective delivery prior to 29 weeks
- Funding opportunity to test the effectiveness of different enhanced prenatal care approaches to reduce premature births among Medicaid or CHIP

The Brooklyn Birth Center is operating under the Strong Start Award to American Association of Birth Centers. The American Association of Birth Centers, Inc. is supporting 23 states with $1,585,122 in total for the first year.[120]

A.1.14 Bundled Payments for Care Improvement (BPCI) Model 2: Retrospective Acute & Post-Acute Care Episode

Bundled Payments for Care Improvement (BPCI) initiative holds providers accountable for the financial and performance outcomes of episodes of care. In Model 2, CMS will provide retrospective payment to hospitals for acute and post-acute episodes of care. Phase 1 participants were announced and have been in "preparation" period since January 2013. Risk-bearing Phase 2 began on October 1, 2013 and will last until October 2014.

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[119] CMS.gov: Innovation Advisors Program http://innovation.cms.gov/initiatives/Innovation-Advisors-Program/.

[120] http://innovation.cms.gov/initiatives/Strong-Start/.

There are eight demonstrations that include New York State hospitals, including several conveners of various hospitals and multi-State initiatives. There are 48 episodes supported by this model, but only a few are supported at each hospital:[121]

- **Catholic Health Services of Long Island** are testing two episodes at St. Joseph Hospital (Bethpage, NY), St. Francis Hospital (Roslyn, NY), Good Samaritan Hospital Medical Center (Islip, NY), St. Catherine of Siena Medical Center (Smithtown, NY), Mercy Medical Center (Rockville, NY) and St. Charles Hospital (Port Jefferson, NY)
- **North Shore-LIJ Health Care Inc.** is testing one episode at Huntington Hospital (Huntington, NY), three at Long Island Jewish Hospital (New Hyde Park, NY) and Southside Hospital (Bay Shore, NY), and four at North Shore University Hospital (Manhasset, NY)
- **Remedy BPCI Partners, Inc.** is testing all 48 episodes at SUNY Downstate Medical Center (Brooklyn, NY), Central Suffolk Hospital (Riverhead, NY), and Hospital for Special Surgery (New York, NY)
- **Touchstone Health** is testing 48 episodes at Richmond University Medical Center (Staten Island, NY)
- **Association of American Medical Colleges** is testing three episodes at the New York University Hospitals Center (New York, NY)
- **Estes Park Institute** is testing five episodes at Canton-Potsdam Hospital (Potsdam, NY)
- **Winthrop-University Hospital** (Mineola, NY) is testing one episode
- **Montefiore Medical Center** (Bronx, NY) is testing five episodes

A.1.15 Bundled Payments for Care Improvement (BPCI) Model 3: Retrospective Post-Acute Care

In Model 3, CMS pays hospitals retrospectively for post-acute care services only.

Visiting Nurse Service of New York Home Care, based in New York, NY, is the only health care facility in the State that is participating in this model. It is one of a number of facilities being convened by Remedy BPCI Partners, LLC, based in Darien, CT, which is testing all 48 available clinical condition episodes. There are

[121] CMS.gov: BPCI Model 2: Retrospective Acute & Post Acute Care Episode: http://innovation.cms.gov/initiatives/BPCI-Model-2/.

no participants in this model with all its included participants in New York State.[122]

A.1.16 Bundled Payments for Care Improvement (BPCI) Model 4: Prospective Acute Care Hospital Stay Only

Under Model 4, CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners will submit "no-pay" claims to Medicare and will be paid by the hospital out of the bundled payment. Related readmissions for 30 days after hospital discharge will be included in the bundled payment amount.

There are three participants from New York State:[123]

- **New York-Presbyterian Hospital** (New York, NY) is testing two episodes
- **North Shore-LIJ Health Care Inc.** (Great Neck, NY) is testing one episode at Staten Island University Hospital (State Island, NY)
- **Health Quest Systems, Inc.** (LaGrangeville, NY) is testing one episode at Vassar Brothers Medical Center (Poughkeepsie, NY), Putnam Hospital Center (Carmel, NY), and Northern Dutchess Hospital (Rhinebeck, NY)

A.1.17 Community-based Care Transitions Program

The Community-based Care Transitions Program (CCTP) tests models that improve transitions from the hospital to other settings and their effectiveness at reducing readmissions for high-risk Medicare beneficiaries. The CCTP is part of the Partnership for Patients, a nationwide public-private partnership that aims to reduce preventable errors in hospitals by 40 percent and reduce hospital readmissions by 20 percent.

There are 12 health care facilities in New York State participating in this initiative, located throughout the state:[124]

- **The Brooklyn Care Transition Coalition** serves Medicare beneficiaries in northern and central Brooklyn at Cobble Hill Health Center, The Brooklyn

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[122] CMS.gov: BPCI Model 3: Retrospective Post Acute Care http://innovation.cms.gov/initiatives/BPCI-Model-3/.

[123] CMS.gov: BPCI Model 4: Prospective Acute Care Hospital Stay Only http://innovation.cms.gov/initiatives/BPCI-Model-4/.

[124] CMS.gov: Community-based Care Transitions Program [http://innovation.cms.gov/initiatives/CCTP/]; CCTP Site Summaries [http://innovation.cms.gov/initiatives/CCTP/CCTP-Site-Summaries.html].

Hospital Center, the Interfaith Medical Center, and Independent Living Systems, Inc.

- **Dominican Sisters Family Health Service, Inc.** will use the LACE index risk prediction model for readmissions to identify 2,000 Medicare beneficiaries in partnership with Southampton Hospital and Stony Brook University Hospital in Long Island, NY.
- **The Eddy Visiting Nurse Association** will coordinate with four local Offices for the Aging, the Columbia Rural Health Consortium, and Greene County Long Term Care Council to expand care transition services at Albany Memorial Hospital, Samaritan Hospital, Columbia Memorial Hospital, St. Peter's Hospital, and Seton Health in Northeastern New York.
- **The Isabella Geriatric Center** will partner with The Allen Hospital, Columbia University Medical Center, Weill Cornell Medical Center, St. Luke's Hospital, and Roosevelt Hospital and the Bridge to Home program to coordinate community service resources and transition services to beneficiaries in the Greater New York City area.
- **Lifespan of Greater Rochester Inc.** will partner with Rochester General, Unity, Strong Memorial, and Highland hospitals, two home health agencies, two community-based organizations, and the Finger Lakes Health Systems Agency to provide care transition services to Medicare beneficiaries in Western New York State.
- **Mt. Sinai Hospital**, in both its Queens and Manhattan locations, will partner with the Institute for Family Health, a federally-qualified health center (FQHC) network to service roughly 4,800 beneficiaries
- **New York Methodist Hospital** will partner with five skilled nursing facilities, two home health agencies, and the Brooklyn Housecall Program, and the Heights and Hills of Brooklyn to serve beneficiaries residing in Brooklyn.
- **The North Country Community-based Care Transitions Program** includes Canton-Potsdam Hospital, Carthage Area Hospital, Inc., Edward John Noble Hospital of Gouverneur, Claxton-Hepburn Medical Center, Lewis County General Hospital, Massena Memorial Hospital, Samaritan Medical Center, and two community-based organizations to serve beneficiaries across a three-county rural region of upstate New York.
- **P2 Collaborative of Western New York, Inc.** includes Brooks Memorial Hospital (Chautauqua), Jones Memorial Hospital (Allegany), Olean General Hospital (Cattaraugus), Orleans Community Health (Orleans), TLC Health Network Lake Shore Health Care Center (Chautauqua), United Memorial Medical Center (Genesee), Westfield Memorial Hospital (Chautauqua), WCA

Hospital (Chautauqua), and Wyoming Community Hospital (Wyoming County).

- **The Queens Care Transitions Collaborative** includes Jamaica Hospital Medical Center, Flushing Hospital Medical Center, New York Hospital Queens, Queens Hospital Center, and Elmhurst Hospital Center and serves beneficiaries in Queens County.
- **Tompkins County, New York Office for the Aging** acts as the lead community-based organization for the Tomkins County Rural Community-based Care Transition Program (TCRCCTP) and will work with Cayuga Medical Center to serve the Finger Lakes region of rural Central New York.
- **Visiting Nurse Service of Schenectady & Saratoga Counties, Inc. (VNS)** will partner with Adirondack Medical Center, Alice Hyde Medical Center, Champlain Valley Physicians Hospital Medical Center, Ellis Hospital, Nathan Littauer Hospital, St. Mary's Hospital at Amsterdam, Saratoga Hospital, and Glens Falls Hospital and six community-based organizations to serve 5,500 Medicare beneficiaries in upstate New York.

A.2 MEDICARE AND OTHER PAYER INITIATIVES AND COLLABORATIONS

A.2.1 Adirondack Medical Home

Medicare, through its Multi-payer Advanced Primary Care Practice Demonstration, has joined with eight payers in New York's Adirondack region to support the transformation of practices into an APC model. The AMHD is a multi-payer five-year pilot (2010–14) that provides improved care and access while containing costs in a rural, upstate region, areas that have been considered the most difficult to transform because they are too small to support the increased costs associated with transformation and HIT. AMHD is also distinctive for developing solutions to the challenges multi-payer arrangements present, including allocating PCMH costs and savings across payers, antitrust issues, securing government engagement (Medicaid and Medicare), and overcoming the natural competitive relationship among payers. The pilot employs a PCMH approach to practice management and recipient engagement. All enrollees are assigned to a physician for face-to-face, continuous, and comprehensive care. Patients of enrolled primary care practices are automatically enrolled if they have had a visit in the last two years.

Transformation costs are supported through increased physician fees paid by Medicaid and other participating payers. Continuing costs are also covered

through a $7 PMPM payment. Participating providers are excluded from (lower) enhanced fees in PCMH incentive programs. There were substantial upfront financial supports totaling $10.4 million from HEAL, HRSA, MSSNY, and others. In 2009–10, a $3 million State budget allocation was passed for MA costs associated with the pilot. Much of the pilot's success is tied to its strong governing structure (a governing council, three sub-regional pods, and practicing providers) that shares in PMPMs and makes decisions by consensus.[125]

A.2.2 FQHC Advanced Primary Care Practice Demonstration

The ACA and 1115 Waiver authority allowed CMS to implement APC principles in FQHCs, a significant source of primary care for Medicare beneficiaries including dual eligibles in New York. Beneficiaries are attributed to a FQHC APC based on claims experience demonstrating primary care service in the past year. Participating FQHCs are expected to achieve Level 3 PCMH recognition, help patients manage chronic conditions, and actively coordinate care. Monthly case management fees ($6 PMPM) will aid the transition.[126]

A.2.3 Medicare Comprehensive Primary Care initiative (CPCi)

Medicare's Comprehensive Primary Care initiative supports the transition of primary care away from FFS and in the direction of risk assumption and shared savings arrangements. It also seeks to move primary care toward more integrated, comprehensive (especially for high-need high-cost populations), and patient-centered care that is rewarding to the primary care physician. If an area seeks to pursue a multi-payer pilot that includes Medicaid, Medicare will fund 100 percent of the cost of any new types of physician services. Under the CPCi pilot, primary care practices must manage care, supports and services for patients with high needs by ensuring access to care, delivering preventive care, engaging patients and caregivers, and coordinating care across the medical neighborhood. In addition to Medicare, the six health plans that are participating are Aetna, Capital District Physicians' Health Plan (CDPHP), Empire BCBS, Hudson Health Plan, MVP Health Care, and the Teamsters Multi-Employer Taft Hartley Funds.

The CPCi supports $20 PMPM Medicare payments (risk adjusted) in the first two years to support necessary increased infrastructure and $15 in years three and four. There are opportunities for shared savings in years two through four. Hudson Valley CPCi Practices tended to have better-than-average EHR and HIE adoption,

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[125] http://www.adkmedicalhome.org/, http://www.rockinst.org/pdf/health_care/2011-02-03-Patient-Centered_Medical5.pdf, http://www.medicalhomeinfo.org/state_pages/new_york.aspx

[126] http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/FQHC_DemoDetails.pdf.

providing a sound HIT infrastructure to enable the pilot, and EHRs are required for participation. The Innovation Center is responsible for collecting sufficient data from primary care practices on a core set of quality measures.

The Taconic Health Information Network and Community (THINC), a RHIO in the Hudson Valley, will provide data and systems to support the project. THINC has historically used its HIT infrastructure and know-how to branch out into other care opportunities via collaborations with providers and payers. THINC specifically tries to foster health homes and engage many smaller-sized practices in HIT via EHR implementations, which has been a significant challenge elsewhere.[127]

A.2.4 P2 Collaborative of Western New York

The P^2 Collaborative of Western New York is an innovative collection of hospitals, other providers, and community organizations that acts as a change agent in health care delivery system reform, originally driven by Independent Health, BC/BS, and Minerva Healthcare. Through a Robert Wood Johnson Foundation grant, Aligning Forces Through Quality, the P^2 Collaborative developed and is now providing a community care coordination model to practices that link physicians with PCMH certification, offer practice consulting support through embedded Practice Enhancement Associates, and empower consumers through self-management programs.[128]

A.2.5 Accountable Care Organizations in NYS

Multiple ACO's are in varying stages of implementation throughout the State. The SHIP will be organized to incorporate and leverage the work of these ACOs which include the following:

- Montefiore Medical Center New York City Pioneer ACO
- Accountable Care Coalition of Mount Kisco
- Accountable Care Coalition of the North Country
- Catholic Medical Partners Buffalo
- Chinese Community Accountable Care Organization New York City
- Crystal Run Healthcare ACO
- Accountable Care Coalition of Syracuse

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127 http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/, http://www.thincrhio.org/comprehensive-primary-care-initiative.html.

128 http://www.pcdc.org/resources/policy/pcdc-tools-resources/building-new-yorks-medical-homes-2012.html.

- Asian American Accountable Care Organization New York City
- Balance Accountable Care Network New York City
- Beacon Health Partners
- Chautauqua Region Associated Medical Partners
- Healthcare Provider ACO, Inc.
- Mount Sinai Care, LLC
- ProHEALTH Accountable Care Medical Group
- WESTMED Medical Group, PC Westchester (Purchase)
- Bon Secours Health System Orange County (Suffern)
- New York City Health and Hospitals Corporation New York City
- Accountable Care Coalition of Greater New York, LLC
- Adirondacks ACO, LLC
- Family Health ACO, LLC
- New York State Elite (NYSE) Accountable Care Organization (ACO), Inc
- Primary PartnerCare Associates IPA, Inc
- Rochester General Health System ACO

Montefiore's Bronx Accountable Healthcare Network (Pioneer ACO)

The ACA provided CMS with the authority and impetus to develop the Pioneer ACO model, intended to help practices consolidate and move from FFS to full risk/global budget through interim steps such as bundled payments and shared savings. Montefiore, a large and innovative medical center experienced in risk arrangements, began its Pioneer ACO model in 2011. Its care models, which explicitly support high-risk high-cost individuals, provide individualized care plans, house calls, in-home medical tests, medical reconciliation, tele-monitoring, psychosocial support, and value-based capitation programs. Payments are made based on a mix of shared savings and actual risk assumption. Early assessment found this Pioneer ACO achieved $23 million in Medicare savings, $14 million of which was returned via the shared savings payment model. [129]

A.2.6 Rochester Medical Home

Rochester Medical Home was a three-year pilot program sponsored by Excellus BCBS and co-administered by MVP to bring the health home concept to primary care practices in Monroe County. Its goals included improved care, reduced overall health care costs, and increased physician satisfaction. The program provided funds allowing for a care manager at the practice and additional

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[129] http://www.montefiore.org/aco, http://www.ilr.cornell.edu/healthcare/Events/upload/05-Chung-Schwartz-The-Montefiore-ACO-and-Behavioral-Health-Integration.pdf, http://www.montefiore.org/body.cfm?id=1738&action=detail&ref=1069.

physician time with patients. Ongoing quality measurement showed improved care and outcomes two years after program startup. Three years after startup, an additional 150 providers had achieved PCMH Level 3 status. Excellus and MVP have obtained a $26 million grant, "Transforming Primary Care Delivery: A Community Partnership," to dramatically expand the model.[130]

A.2.7 Empire BlueCross BlueShield Medical Home Demonstration

Originally conceived as a test of whether PCMH recognition was associated with improved outcomes and lower costs, the Empire BCBS Medical Home Demonstration program evolved into a health home with shared savings, additional payments to help support upfront costs, and use of WellPoint's EHR system. This pilot utilizes a web portal where providers can access patient claims, lab data, predictive modeling, care-management gaps, and front-end eligibility. Empire BCBS has dedicated resources that go out to practices to educate providers in how to use data, and an amendment to the payer–provider contract includes PCMH-type criteria to which providers must adhere in order to receive data.

Elements of the Medical Home Pilot have also been adopted by Empire BCBS' Patient-Centered Primary Care Program, which has 5,000 participating providers. The program does not require NCQA certification. It offers a care coordination fee for longer hours, greater access, and development of care-management plans. It also offers upside savings based on the attainment of a minimum quality threshold. All providers use a shared-savings model. In January 2013, the pilot program ended and the ongoing program is now called the Patient-Centered Primary Care Program.[131]

A.2.8 Independence at Home Demonstration

The Independence at Home Demonstration tests the effectiveness of home-based primary care services in improving care for Medicare beneficiaries with multiple chronic conditions. Participants will provide home-based care to targeted beneficiaries for a three-year period. Practices that succeed in meeting quality metrics while generating Medicare savings will have an opportunity to share in savings after meeting a minimum savings rate. Both Comprehensive Geriatric Medicine P.C. d/b/a Doctors on Call (Brooklyn, NY) and North Shore-LIJ Health

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130 www.excellusbcbs.com.

131 http://www.pcdc.org/assets/pdf/building-new-york-s-medical-homes-11-18-12-final.pdf.

Care Inc.: Physician House Calls Program (Westbury, NY) were announced as individual participants in April 2012.[132]

A.3 BROADER HEALTHCARE DELIVERY SYSTEM INITIATIVES

A.3.1 New York Health Benefit Exchange

After the New York State legislature failed to pass exchange legislation, Governor Cuomo signed Executive Order 42 on April 12, 2012, to establish the New York Health Benefit Exchange, which received approval from the US Department of Health and Human Services in December 2012. NYS received federal grants totaling more than $367 million to support creation of the exchange. New York State participates in the "Enroll UX 2014" project, a public–private partnership creating design standards for exchanges that all states can use.

Qualified Health Plan (QHP) certification proposals were accepted starting in March 2013, which was the health plans' last opportunity to apply before 2015. All plans were posted to the exchange website in September 2013, and open enrollment began October 1, 2013. Currently, the exchange accommodates new Medicaid enrollees; existing Medicaid patients will also be rolled into this exchange in the future. Significant future milestones include January 2014, when insurance coverage commences, the individual mandate begins, and Medicaid expansion starts. In January 2015, the exchange must be self-sufficient as federal financial support ceases. At this point, the provider mandate will also begin. In January 2017, states will have the option to allow businesses with more than 100 employees to join smaller businesses in purchasing coverage for their employees on the Small Business Health Options Program Marketplace. The exchange will be a key component in bringing health insurance to more than 1 million currently uninsured individuals under the ACA.[133]

A.3.2 Consolidated health care systems in NYC

North Shore-LIJ and NYC Health and Hospitals, two of NYS's largest health systems, have active ACO pilots underway including both the MSSP and Pioneer ACO models. NYC HHC and MetroPlus Health Plan are designated as a Medicaid Health Home by NY DOH. They receive monthly payments from the State to

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[132] CMS.gov: Independence at Home Demonstration http://innovation.cms.gov/initiatives/Independence-at-Home/#collapse-tableDetails.

[133] Kaiser Family Foundation: State Exchange Profiles: New York.

manage care of Medicaid patients with complex conditions in Brooklyn and the Bronx.[134]

[134] HealthLeaders InterStudy New York City MSA Market Overview, 2013 based on Billian's HealthDATA, 2012; American Hospital Directory, Becker's Hospital Review, "Mount Sinai, Continuum Health Partners Sign Definitive Merger Agreement," July 17, 2013.

Appendix B. Current Workforce Initiatives

B.1. KEY EXISTING CHALLENGES AND TARGETED INITIATIVES: CAPACITY

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
Capacity	Primary care provider shortage/ mal-distribution	Attraction/ Recruiting/ Retention	AHEC	AHEC	■ Creates opportunities to train health care professions and increase workforce diversity in underserved areas ■ Provides training opportunities through CME and other training workshops ■ Encourages young people, especially those from under-represented and disadvantaged backgrounds, to pursue health careers	■ Over 2,100 medical, nursing, and health profession students ■ Over 13,000 college, HS, and elementary students
			DOH	Doctors Across NY (DANY) – Physician Practice Support (PPS), and Loan Repayment (LR)	■ Provides up to $100,000 in funding over 2 years to applicants who can recruit a licensed physician who has completed training and will commit to a 2-year service obligation in an underserved region within NYS ■ Provides up to $150,000 in funding over 5 years for physicians who commit to a 5-year service obligation in an underserved region ■ (Annually funding amounts do not provide for new cycles/awards each year)	■ 2013 – $4.3m annually for PPS – 56 new awards in 2013 ■ 2013 – $1.7m annually for LR – 26 new awards in 2013 ■
			HHS	National Health Ser-vice Corp	■ Provides loan repayment for clinicians providing primary, oral, or behavioral health care in underserved populations (up to $60,000 for 2 full-time years)	■ 2013 – 294 primary care, 56 dental, 124 behavioral health

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
			DOH	Visa waiver	■ Grants a waiver of the exchange visitor home residency requirements in exchange for the physician's service in a medically underserved area of NYS	■ 2013 – 30-40 participants
			DOH	DANY Ambulatory Care Training	■ Provides grants to 14 medical education institutions to train residents and medical students in 34 free-standing community health centers or private physician offices. Projects began in July 2012	■ 2012-13 – $8.6m over 3 years, ~850 residents and students
			DOH	The Hospital Medical Home (HMH)	■ Transforms the primary care provided by residency programs to Medicaid members, improves hospital quality and safety, and trains the next generation of primary care doctors in the new health care paradigms of patient-centered medical homes, population health, and hospital safety. Funds have been awarded to hospitals across the State who have developed and submitted to DOH formal work plans, representing the participation of 64 hospitals, 170 residency training clinics and 5,000 primary care residents that are providing primary care to over 1 million Medicaid members	■ "$250 m over 2 years through the 2010 1115 Waiver
			DOH	Incentive Program for Medical Residents	■ Provides enhanced salaries to residents during their training who agree to work in a rural or other underserved community following completion of their residency. $20–40k additional salary (page 85 of the waiver)	■ Awaiting waiver approval, planning for cohorts of 100-200 per year in each of 4 years
	Primary care provider shortage/	Attraction/ Recruiting	DOH	Primary Care Service Corp	■ Provides non-physician clinicians who offer primary care, oral, and outpatient behavioral health services and serve a not-for-profit facility in a federally-designated area (HPSA) up to $60,000 ($30,000 part	■ 2013 – up to 37 awards (no waitlist currently)

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
	mal-distribu-tion				time) to repay qualified educational debt in return for a minimum 2-year work commitment	
			HRSA	Federal Teaching Health Centers	■ Provides grant support to community health center-sponsored residency programs to train primary care physicians in underserved areas	■ 2013 – $10m in grants awarded to 4 centers over a 3-year period to train over 70 family medicine residents
		Training/ Incentive	DOH	Health Workforce Retraining Initiative	■ Provides grants to hospitals, nursing homes, and other entities to train/retrain health care workers for new positions in shortage occupations (nurses, midlevel practitioners, home health aides, resident assistants, technicians, technologists, therapists, social service workers, care coordinators, and others types of workers)	■ 2013 – $26.8m to 30-40 organizations reaching 8-10,000 workers per year
	Care coordinator	Training/ Incentive	DOH	Health Workforce Retraining Initiative	■ See description above	■ …
	Care coordinator	Training/ Incentive	N/A	GNYHA teaching clinic redesign	■ Since 2011, the Greater New York Hospital Association (GNYHA) has been engaged in a teaching clinic redesign project to assist residency programs and clinic sites in improving the residents' learning experience and the ambulatory patient care experience. A compendium of resources entitled Redesigning the Teaching Clinic: A Toolkit for Improving Care Coordination and Resident Learning was developed. Over the course of the past year, GNYHA has been working on assisting hospitals to	■ Toolkit available State-wide

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
					implement the practices outlined in the toolkit. Some of these projects include reorganizing resident schedules to improve continuity, enhance teamwork and implement team-based care, and incorporate patient-centered medical home (PCMH) concepts into ambulatory operations and the resident's learning experience. This work has complemented the ongoing efforts for hospitals participating in the HMH	
	Other	Training/ Incentive	DOH	Rapid Response	■ Provides short-term counseling, training, and placement for displaced health workers	■ Number of health workers varies, occurs with hospital or nursing home closures or downsizing
	Diversity across roles	Attraction/ Recruiting	AHEC	AHEC	■ Encourages young people, especially those from under-represented and disadvantaged backgrounds, to pursue careers in health ■ (see top of page 1 for complete description)	■ Over 2,100 medical, nursing, and health-profession students trained by 570 preceptors
			DOH	DANY/ Diversity in Medicine	■ Grants to the Associated Medical Schools of NY to manage 10 separate programs along the educational pipeline to support training in medicine and the health professions to minorities and financially disadvantaged students. Nearly 2/3 devoted to post-baccalaureate programs	■ $1.6m annually
			DOH	Diversifying Medical	■ Exploratory group to increase flexibility in admission criteria to nontraditional backgrounds to	■ Pilot at Mt. Sinai School of

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
				School Admission Criteria	enhance the prospect of students entering medical school and eventually practicing in primary care fields	Medicine (85 students between 2005-09)

B.2. KEY EXISTING CHALLENGES AND TARGETED INITIATIVES: CAPABILITIES AND WORKFORCE PLANNING

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
Capabil-ities	Tele-health experience	Producti vity	DOH	Survey	■ Conducting survey to understand who is using tele-health, who is not, and barriers to use	■ Survey only
	Technology utilization	Incentive and training	RECs	EHR training	■ Provides support to Medicare / Medicaid providers on EHR vendor selection, adoption, and implementation	■ 2013 – 1,400 providers (9,000 since 2007)
Workforce data collect, analysis, and planning	Compre-hensive workforce planning	Convening	SUNY/ Center for Work-force Studies	Local health planning	■ Provides timely, accurate data and conducts policy-relevant research about the physician, resident, and health practitioner workforce	■ $185k annually
			SUNY	Gap analysis	■ DOH conducting regional stakeholder workshops to collaboratively plan health workforce development to address identified gaps and future needs	■ Unknown
			DOH	Local health planning	■ DOH working with its Public Health and Health Planning Council to define precise structure and functions of regional planning entities, potential regional boundaries, process for selecting regional planning organizations, and metrics for their performance	■ Portion of overall $25m grant
			DOH	DANY/ Physician Health	■ Provides funding to the Center for Health Workforces Studies at SUNY Albany for a series of integrated projects that support assessment of present and future health care practitioner workforce capacity in NYS	■ $1.4m over 3 years
Flexibility	Workforce flexibility/ Scope of	Regulation	DOH	MRT - 5501	■ Improves health workforce flexibility in NYS, including, but not limited to, proposals to develop, expand, or modify scopes of practice for health care	■ Work in progress, developing proposals

Challenge	Factor	Lever	Lead	Initiative	Activities	Scope
	practice/ practice at top of license				professionals; scopes of services for assistive health personnel	
				MRT – 5502D	■ Allows practice of dental hygiene under a collaborative practice agreement rather than under supervision of a licensed dentist. Redefine practice of dental hygiene in accordance with dental hygiene process of care	■ Approved by State
				MRT – 5502E	■ Removes arbitrary restriction on the number of physician assistants a physician may supervise, allowing physician to determine staffing at the practice or facility	■ Revising draft to submit to DLA
				MRT – 5503A	■ Enables use of practice protocols, or "standing orders," in defined situations	■ Work in progress, developing proposals
				MRT – 5503B	■ Allows all Article 28-licensed hospitals and D&TCs to provide practitioner home-visit services to chronically ill, homebound Medicaid patients	■ Finalizing draft regulations
				MRT – 5503C	■ Stackable certification and credentials for direct care workers	■ Collecting data from impacted State agencies
				MRT – 5505	■ Continues permitting activities or services on the part of specific titles in the employ of a program or service operated, regulated, funded, or approved by NYS agencies to continue to serve without licenses in their current capacities	■ Collecting data from impacted State agencies

Appendix C. Consumer Engagement

C.1. EXAMPLES OF CURRENT TRANSPARENCY AND CONSUMER-ENGAGEMENT PROGRAMS

Challenge	Solutions	Lead	Activities	Scope
Transparency	Cost and quality information available for consumers	Payers	■ Provides varying levels of cost and quality information on their websites	Varies by payer
		State	■ Compiles cost information on optional basis and publishes annual report	Statewide
		Community health centers	■ Provides education about provider options and offer consumers support in making health care decisions	Statewide
	Consumer access to medical records	State	■ Provides incentives to providers who adopt, implement, or upgrade certified EHR technology and subsequently become meaningful users	Varies by provider
Maximizing value of healthcare utilization	Value-based insurance plans (VBID)	Payers	■ Includes VBID components into offering (e.g., free prevention screenings)	Varies by payer
		Employers	■ Offers incentives for exercise, employee health competitions, and VBID health plan components	Varies by employer; not extensive
Consumer engagement effectiveness	Provide information or services directly to consumers	State	■ **Cancer Services Program.** Provides consumer entry point to identify and access available local cancer–oriented resources	Statewide
			■ **New York Connects.** Provides local LTC information and specialists for personalized counseling in making informed decisions about and access to LTC services	Statewide
			■ **New York OMH Suicide Prevention.** Offers a 24-hour hotline, regional local prevention centers to provide counseling, and a training	Statewide

Challenge	Solutions	Lead	Activities	Scope
			program for suicide prevention	
			■ **New York State Tobacco Control Program.** Provides direct resources to consumers, including nicotine replacement therapy, education, 24-hour coaching, smartphone app, and support groups	Statewide
Consumer engagement effectiveness (continued)	Provide information or services directly to consumers	Community Healthcare Network (organization of health centers)	■ Provides education and basic health care services through workshops, mobile services, health fairs, and outreach to underserved populations in Manhattan and Brooklyn	Manhattan and Brooklyn only
	Build capacity / capability of other stakeholders	State	■ **NYS HIV Quality of Care (QOC) Learning Networks.** Builds capacity of HIV programs through convening of stakeholders, trainings, and coaching to improve the quality of patient care and patient experience	Statewide
			■ **Promote breastfeeding.** Work with employers to increase ease of breastfeeding in the workplace	Statewide
			■ **Diabetes prevention and management.** Provides grants to communities to provide diabetes education and support	Statewide
			■ **Healthy Place to Live, Work, and Play.** Provides grants to promote physical activities and healthy eating	Statewide
	Testing new approaches	New York City Economic Development Corporation	■ **"Smart" pill bottle testing.** Provided grant to test Wi-Fi- enabled pill bottles that automatically text reminders to increase medication adherence in HIV-positive consumers	New York City only

Appendix D. Report on Design Process Deliberations

This appendix has been prepared in response to section 7, "Scope of Design Project" of the CMS State Innovation Models Pre-Testing Assistance Cooperative Agreement Award: Standard and Special Terms & Conditions, Attachment B. This attachment requires each recipient state of a Pre-Testing Award, in revising its State Health Innovation Plan, to consider levers and strategies that can be applied to influence the structure and performance of the state's entire health care system, as stated in the Funding Opportunity Announcement.

In line with the CMS guidance, this appendix reflects considerations of the following 14 pre-specified topics: behavioral health integration; multi-payer approach; commercial payer commitments; achieving 80 percent preponderance of care, support and services; health care workforce; provider engagement; coordination with non-profit hospitals; coordination between providers and public health; the State's Winnable Battles; the public health role in the Plan; community stabilization development initiatives early childhood and adolescent health prevention strategies; primary care and behavioral health evaluation; and the overall evaluation plan.

Each of these topics is also described within the main body of the Plan, frequently cutting across several sections. Hence, for each topic, one section number is provided to highlight the most relevant section for reference.

a) Primary care and behavioral health integration ("Provide Integrated Care for All")

"Clarify how the outcome of the integration of primary care and behavioral health will lead to a health system transformation for the State"

In order to successfully transform the health system, NYS needs to tackle quality of care in behavioral health. It is estimated that only about 25 percent of patients with depression and other low-acuity mental health conditions receive effective care, supports and services. To improve their care, NYS plans to integrate behavioral health care within primary care, because only 20 percent of adult patients with mental health disorders are seen by mental health specialists. Specifically, the Plan proposes a new primary care delivery model, whereby enhanced APC providers are responsible for integrating the Collaborative Care approach into their standard primary care practices. Research literature suggests that the Collaborative Care approach improves outcomes for mental health and other chronic health conditions, such as diabetes, hypertension, and high

cholesterol. In addition, the approach typically reduces referrals to costly specialty mental health care facilities.

b) Multipayer approach ("Transformation Roadmap")

"Incorporate multiple payers (i.e., commercial payers, Medicare, Medicaid, CHIP, and State employee health benefit programs) into the plan"

The "Transformation Roadmap" section describes a five-year roadmap consisting of four phases: detailed design, implementation planning, launch and scale-up. The State plans to involve multiple payers throughout all four phases. During the nine-month detailed design phase (January – September 2014), payer groups will meet four-to-five times and be charged with aligning on definition of the levels of APC, recognition criteria, evaluation metrics, overall approach to and best practices for care coordination and practice transformation, payment models, workforce initiatives, and approach to HIT requirements and support. To engage payers, they will receive a case for change communication, detailing why transitioning to new care and payment models supported by appropriately trained workforce, transparent evaluation and relevant HIT will improve outcomes and costs in the NYS health care system. All payers will be invited to meetings, and attendance is specifically expected from larger entities, including Medicare, Medicaid, CHIP, and State employee health benefit programs, as well as the following commercial payers: Aetna, United, Emblem, Empire BCBS, Fidelis, Healthfirst, Amerigroup, Metroplus, CDPHP, Excellus, HealthNow, MVP Health Care, Independent Health (of Buffalo).

c) Commercial payer's commitments ("Paying for Value not Volume")

"Clarify if commercial payers will commit resources or funding to the delivery system transformation"

The Plan described statewide health system goals in the "Paying for Value not Volume" section. Achieving these goals will require significant commitment from all payers involved, including commercial payers. Specifically, payers will commit resources and funding to transform primary care delivery towards APC, in particular through care coordination and practice transformation support. Moreover, compensation for care delivery needs to be aligned with health system goals. Hence, this section describes the fourth pillar of the Plan, "Paying for Value not Volume", which aims to move payment models across all payers, including commercial payers, from pure fee-for-service (FFS) contracts to more sophisticated and innovative financial arrangements that align payment with health system goals.

d) Achieving 80 percent preponderance of care ("Provide Integrated Care for All")

"The Models will include the preponderance of care (up to 80 percent within five years) across all populations in the state."

Across all populations in the state, the five-year goal is to have 80 percent of New Yorkers in a recognized integrated care model and for the same percentage to receive care under a value-based financial arrangement. Meeting the 80 percent preponderance of care target by the end of 2018 will signal success for the Plan.

As described in the "Provide Integrated Care for All" section, recognized integrated care models include not only APC but also existing initiatives such as Medicaid health homes and FIDA. Moreover, in an effort to effectively serve about 80 percent of New Yorkers, who are healthy or only have acute or single chronic conditions, one key component of the APC model is high quality preventive care and behavioral health integration.

As described in this section, value-based financial arrangements include pay for performance, gain sharing, capitation and all other varieties of risk sharing. Reducing the share of services paid for under fee-for-service payment arrangements for 80 percent of New Yorkers will signal success here.

e) Health care work force ("Workforce Development")

"Work to develop innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through:

- *policies regarding training (specifically, graduate medical education, allied health professionals, nursing, dental, and direct service workers)*
- *professional licensure*
- *reviewing scope of practice statutes"*

New York is undertaking an ambitious, broad reaching, effort through the pending MRT 1115 waiver to address workforce challenges in the near-term. To fully shift the state's health care workforce toward the future care model as well as address structural shifts in the health care environment, the workforce development section of the Plan builds on these efforts with longer-term systemic interventions to align NYS workforce capacity, capabilities, and flexibility. Specifically, the Plan proposes to expand the supply of the clinically trained workforce in key geographies and settings by working with providers and educators to change admissions, training, recruitment, and retention approaches, collaborate to update competencies and educational programs to reflect the needs of delivering the APC, and develop the infrastructure to test and evaluate workforce models of care,

supply, and demand to identify potential mismatches and opportunities to further prepare our workforce for the future.

f) Provider engagement ("Transformation Roadmap")

"The engagement of State health care providers committed to the delivery system transformation"

The Transformation roadmap of the Plan describes a five-year roadmap consisting of four phases: detailed design, implementation planning, launch, and scale-up. The State plans to involve providers throughout all four phases. During the nine-month detailed design phase (January – September 2014), provider groups will meet four-to-five times and be charged with aligning on definition of the levels of APC, recognition criteria, evaluation metrics, overall approach to and best practices for care coordination and practice transformation, payment models, workforce initiatives, and approach to HIT requirements and support. To engage providers, they will receive a case for change communication, detailing why transitioning to new care and payment models supported by an appropriately trained workforce, transparent evaluation and relevant HIT will improve outcomes and costs through the NYS healthcare system. Also, to ensure provider engagement, incentives and operating models proposed by the Plan need to be made both financially and operationally viable from the start. Provider meetings will likely be attended by representatives from provider associations, physician groups, nursing associations, and academic medical centers. Attendance is specifically expected from American College of Physicians, , American College of Physicians, Greater New York Hospital Association, Healthcare Association of New York State, Health and Hospitals Corporation, Medical Society of the State of New York, New York State Nurses Association, and others.

g) Coordination and collaboration with non-profit hospitals community benefits/community building plans

Collaboration is an essential element for improving population health in communities and in the State as a whole. In keeping with the NYS Prevention Agenda 2013-17, the DOH is asking local health departments and hospitals to collaborate with each other and community partners on the development of a Local Health Department Community Health Assessment[135] and associated

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[135] The Community Health Assessment is a description of the community being assessed. For local health departments this means at a minimum the jurisdiction served by the local health department. In addition, it should include a succinct narrative and graphical description of

a. The demographics of the population served
b. The health status of the population and the distribution of health issues
c. Identification of the main health challenges facing this community and a discussion of the contributing

Improvement Plan for 2014-2017. The same stakeholders are asked to collaboratively complete a Hospital Community Service Plan (CSP)[136] for 2013-2015, that mirrors the Community Health Needs Assessment and Improvement Strategy required by federal law for nonprofit hospitals per the Affordable Care Act. Working together to develop these documents will reduce duplication and assist local health departments and hospitals to conduct this work in an effective, efficient manner.

h) Coordination between providers and public health ("Connect Primary Care to Population Health Improvement")

"State plans to coordinate work and participation between health care providers and public health"

The State plans to coordinate work and participation between health care providers and public health through a wide range of activities. Two key strategies are local health department-hospital collaboration to create Community Health Assessments and Hospitals CSPs (see section g of this appendix), as well strengthening linkages between primary care practices and community resources as described in the "Connect Primary Care to Population Health Improvement" section of the Plan and section j of this appendix.

i) State's Winnable Battles ("Performance Measurement and Evaluation")

"The State's Winnable Battles in assisting the progress in payment and delivery system reform"

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causes of the health challenges, including the broad determinants of health
d. A succinct summary of the assets and resources that can be mobilized and employed to address health issues identified.

[136] The Hospital Community Service Plan (CSP) has seven key components that illustrate hospital-community linkages

a. Hospital mission statement that identifies commitment to the community served.
b. Definition and brief description of the community served, aligned with the local health department Community Health Assessments
c. Information on public participation sessions, including the participants involved, dates, as well as a brief description of the outcomes and how public notification of these sessions was accomplished
d. Description of the collaborative process and criteria used to identify at least two NYS Prevention Agenda 2013-2017 priorities
e. Three-year plan of action for the two Prevention Agenda priorities that the hospital is addressing with the local health department
f. Description of how the Three Year Plan is made widely available to the public
g. A brief description of the process that will be used to maintain engagement with local partners over the three years of the Community Service Plan, and the process that will be used to track progress and make mid-course corrections.

The Winnable Battles initiative created by the Centers for Disease Control (CDC) and Prevention to address leading causes of death and disability in the United States have been supported and promoted by DOH in a variety of settings and through multiple initiatives. Most recently the NYS Prevention Agenda 2013 - 2017 incorporates many of the Winnable Battles identified by the CDC and seeks to realize significant change over the coming five years. Specific CDC Winnable Battle 2015 public health areas that have been included as part of the NYS Prevention Agenda 2013-2017 goals and objectives include the following:

- Tobacco
- Nutrition, Physical Activity, and Obesity
- Healthcare-associated Infections
- Teen Pregnancy
- HIV

Those Winnable Battles that have been adopted as part of the NYS Prevention Agenda 2013-2017 are also incorporated in this Plan. There will be measures in the standardized APC scorecard to also evaluate success of specific Winnable Battles over time (the "Performance Measurement and Evaluation" section for details of the proposed APC scorecard and evaluation process). Details on NYS Prevention Agenda 2013-2017 public health goals and objectives, inclusive of those that are Winnable Battles, will be publicly reported on openNY.gov.[137]

Winnable Battles not included in the NYS Prevention Agenda 2013-2017, but for which there are targeted initiatives in NYS, include:

- Motor Vehicle Safety: NYS aims to reduce fatalities due to motor vehicle crashes through consumer outreach and education, tool kits related to motor vehicle safety, and regularly tracked statistics to inform policy and program.
- Food Safety: The NYS DOH's Bureau of Community Environmental Health and Food Protection works to decrease incidence of foodborne illness in communities by ensuring that the more than 90,000 food service establishments in New York are operated in a manner that eliminates hazards through design and management. The Bureau's Food Protection Program coordinates foodborne outbreak investigations, analyzes the findings, and uses this information to develop regulations and guidance designed to prevent similar outbreaks in the future. The Program also provides guidance and assistance to county and city health departments and State District Offices, which in turn permit and inspect food service establishments, some

[137] https://health.data.ny.gov/Health/Prevention-Agenda-2013-2017-Tracking-Indicators-Co/cekp-nqfv.

institutional food services, temporary and mobile food service establishments, and food and beverage vending machines.

j) Public health role in the Plan ("Connect Primary Care to Population Health Improvement")

"The public health role in the State Health Innovation Plan to achieve New York's goals of achieving the Triple Aim of better care, better health, and lower costs across all payers"

The Plan aims to support the Triple Aim of improved health, better health care and lower costs through five strategic pillars. While all of them lay out some public health role, pillar five on "Strengthening community linkages" is particularly focused on public health improvement. This pillar demonstrates the State's commitment to improving public health and disease prevention through enhanced connections between primary care and community-based organizations that understand and impact health outcomes at a local level. This section describes six capabilities and tools needed to strengthen clinical-community linkages in NYS, which build on and align with existing initiatives that drive improvement in public health across the State.

k) Community stabilization development initiatives

"The plans to identify options for leveraging community stabilization development initiatives in low- income communities and encouraging community investment to improve community health"

One cross-agency initiative that reaches beyond the health care delivery system into low income communities to improve health outcomes was announced in Governor Cuomo's 2013-2014 State of the State: the Community, Opportunity and Re-Investment (CORe) initiative. The overarching vision of CORe is to improve the collective impact of services, supports and opportunities available at the neighborhood level in order to measurably impact eight goals and objectives, including "Improve health throughout the lifespan" and "Ensure equal access to necessary human services to eliminate disparities in outcomes".

CORe will link up to ten participating State agencies, partners and neighborhoods across several issue areas, including health services, child welfare, substance abuse, and economic development to better align State support with local needs. This collaboration and support focused on successful community-based efforts with measurable outcomes is expected to create cost savings as well as sustainable and measurable improvements in community outcomes.

In this initiative, NYS is taking a comprehensive look at how multiple investments in a particular neighborhood can be better coordinated and aligned behind

evidence-informed practices to increase impact and promote efficiencies. A first step is to precisely identify distressed neighborhoods in need of attention. It is hoped that these efforts will help the Department better understand the economic and social basis of health disparities and provide a remediation tool. Second, local communities would be given three kinds of resources from the State: 1) a technology solution to individuals with multiple needs in order to engage them earlier and more effectively in services; 2) a community conditions survey tool that will identify opportunities for short-term changes with the real potential to effect long-term change—starting to drive numbers in the right direction while also further engaging the community; and 3) technical assistance to create and support a local CORe team; strengthening partnerships as an independent entity; and building organizational and leadership capacity. There are several federal initiatives supporting this approach, but no state has yet taken a similar comprehensive look at neighborhood revitalization.

The Plan will be structured to assure local planning entities, described in the "Connect Primary Care to Population Health Improvement" section are well integrated with CORe initiatives where appropriate. To date there are two communities actively engaged in CORe, Newburgh and Albany. Additional communities will become operational during 2014-2015.

l) Early childhood and adolescent health ("Connect Primary Care to Population Health Improvement")

"Ways the State will integrate early childhood and adolescent health prevention strategies with the primary and secondary educational system to improve student health"

New York State is embarking on a number of initiatives to better integrate programs and services across agencies and sectors to provide a holistic approach to early childhood and adolescent health and well-being. Three initiatives are described below.

First, Governor Cuomo introduced the Community Schools initiative in his 2013 State of the State agenda and 2013-14 Executive Budget. This initiative builds on evidence of promising practices from successful community schools[138] across the

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[138] Community Schools are public schools that emphasize family engagement and are characterized by strong partnerships and additional supports for students and families designed to counter environmental factors that impede student achievement. While some of the characteristics of Community Schools vary based on the needs of the specific community, all Community Schools share three essential elements:

- A rigorous academic program with strong supports to prepare all students for college, careers and citizenship, and that supplements quality curriculum with expanded learning opportunities that keep students engaged, coupled with high levels of accountability for results;

State and nation, reflects recommendations of the New NY Education Reform Commission, and is consistent with the New York State Board of Regents' advocacy for establishing programs for students and families that provide academic enrichment activities along with a broad array of student and family development opportunities within their communities. Where a Community School has identified a priority or need, the State will work with it through existing programs, which may include referrals for medical, dental, and other health services, as well as defraying excess cost of transportation (e.g. portion of transportation expense not covered by State Aid or Medicaid reimbursement).

Second, the proposed RHICs will be tasked with coordination and integrations of multiple regional health improvement initiatives including initiatives related to early childhood and adolescent health -- for example the CORe and the Community Schools Program – where appropriate.

Third, the Commissioner of the State Education Department (SED) is authorized to award competitive grants "to eligible school districts for plans that target school buildings as 'community hubs to deliver co-located or school-linked academic, health, mental health, nutrition, counseling, legal and/or other services to students and their families in a manner that will lead to improved educational and other outcomes.'" Awards for 2014 were announced December 19, 2013.

m) Primary care & behavioral health evaluation ("Performance Measurement and Evaluation")

"The State's plans for measurement and evaluation to determine the outcome of integrating physical and behavioral health care in the health care delivery system"

Integrating physical and behavioral health care in the health care delivery system is a top priority for the State of New York, and much work has been done in developing the collaborative care approach. To ensure the APC model and collaborative care approach complement one another and work together, the APC scorecard incorporates the same metrics used to evaluate the collaborative care approach, for example tracking behavioral health screening tests and new depression diagnosis.

- A full range of school-based and school-linked programs and services that, based on a needs assessment of the community, address the comprehensive needs of students and their families and that work with families as essential partners in student success; and
- Partnerships that demonstrate collaboration with the local community, including by engaging families and other community stakeholders. These partnerships draw on a broad set of resources, and incorporate local and State government agencies, non-profit service providers, institutions of higher education, and the philanthropic and business communities in order to extend the impact and depth of services and programs.

n) Evaluation plan ("Performance Measurement and Evaluation")

"An evaluation plan designed to inform health authorities or policy makers on the relative merits of the State Health Care Innovation Plan"

The evaluation approach described in the "Performance Measurement and Evaluation" section has two distinct objectives, the first of which is to measure the progress of the overall Plan toward its overarching goals of achieving the Triple Aim and of statewide health system transformation. The second goal is to specifically monitor how the APC model progresses towards achieving the Triple Aim for the patients, providers and payers enrolled in APC. In designing the evaluation approach with these goals in mind, the Plan focused on developing a core set of metrics to be standardized across all payers, building on existing NYS measurement approaches, working to minimize reporting burdens, enhancing transparency to all stakeholders and promoting continuous performance improvement.

Appendix E. Recognition for Existing Medical Home Models

NCQA PCMH 2011 Standards

There are three levels of NCQA PCMH Recognition; each level reflects the degree to which a patient-centered medical home practice meets the requirements of the elements and factors that comprise the standards. The PCMH 2011 program has six standards (see Table below) that align with the core components of primary care. There is one overall score for these six standards, with five possible scoring levels for each element (100%, 75%, 50%, 25%, 0%).

PCMH 2011 also has six must-pass elements, which are considered the basic building blocks of a PCMH, and are required for practices at all recognition levels. Practices must achieve a score of 50 percent or higher on all six must-pass elements:

The practice's recognition determination is based on its overall performance (numeric score) and allows practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three PCMH levels is as follows.

- Level 1: 35–59 points and all 6 must-pass elements
- Level 2: 60–84 points and all 6 must-pass elements
- Level 3: 85–100 points and all 6 must-pass elements

EXHIBIT 30: NCQA PCMH 2011 STANDARDS

Table 1: Summary of NCQA PCMH 2011 Standards

Standard	Content Summary
PCMH 1: Enhance Access/Continuity	• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours • The practice provides electronic access • Patients may select a clinician • The focus is on team-based care with trained staff
PCMH 2: Identify/Manage Patient Populations	• The practice collects demographic and clinical data for population management • The practice assesses and documents patient risk factors • The practice identifies patients for proactive reminders
PCMH 3: Plan/Manage Care	• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems • Care management emphasizes: – Pre-visit planning – Assessing patient progress toward treatment goals – Addressing patient barriers to treatment goals • The practice reconciles patient medications at visits and post-hospitalization • The practice uses e-prescribing
PCMH 4: Provide Self-Care Support/Community Resources	• The practice assesses patient/family self-management abilities • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources • Practice clinicians counsel patients on healthy behaviors • The practice assesses and provides or arranges for mental health/substance abuse treatment
PCMH 5: Track/Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals) • The practice manages care transitions
PCMH 6: Measure/Improve Performance	• The practice uses performance and patient experience data to continuously improve • The practice tracks utilization measures such as rates of hospitalizations and ER visits • The practice identifies vulnerable patient populations • The practice demonstrates improved performance

Trained NCQA internal and external surveyors access the Survey Tool after the practice submits it to NCQA. The surveyors evaluate the responses and documentation against program standards and determine scores for each relevant element and standard. NCQA makes its final scoring decision within 60 days of receiving a completed Survey Tool.

NCQA reserves the right to audit any practice that has applied for NCQA Recognition while the practice's application is under review. An audit validates documentation, stated procedures, and responses given by a practice in its application and Survey Tool. NCQA audits five percent of practices, either by specific criteria or randomly, before making a decision about whether the practice meets PCMH requirements. Audits may be completed by e-mail, teleconference, Webinar, onsite review, or other electronic means. Failure to agree to an audit, failure to pass an onsite audit, or failure to pass an audit of Survey Tool responses and documented elements may result in a status of Not Recognized.

EXHIBIT 31: CPCI INITIATIVE MEASURES

NQF ID	Clinical Quality Measure Title	Required in 2013	Required in 2014 & 2015	Domain
0018	Controlling High Blood Pressure	Yes	Yes	Clinical Process/ Effectiveness
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Yes: CO, OK, OR No: AR, NJ, NY, OH	Yes: CO, OK, OR No: AR, NJ, NY, OH	Population/ Public Health
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	Yes	Population/ Public Health
0031[1]	Breast Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
0034	Colorectal Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
0036	Use of Appropriate Medications for Asthma	Yes: CO, NJ, NY, OH, OK, OR No: AR	Yes: CO, NJ, NY, OH, OK, OR No: AR	Clinical Process/ Effectiveness
0041	Preventive Care and Screening: Influenza Immunization	Yes	Yes	Population/ Public Health
0059	Diabetes: Hemoglobin A1c Poor Control	Yes	Yes	Clinical Process/ Effectiveness
0061	Diabetes: Blood Pressure Management	Optional[2]	No	Clinical Process/ Effectiveness
0064	Diabetes: Low Density Lipoprotein (LDL) Management	Yes	Yes	Clinical Process/ Effectiveness
0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Yes	Yes	Clinical Process/ Effectiveness
0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	Yes	Clinical Process/ Effectiveness
0101	Falls: Screening for Future Fall Risk	No	Yes	Patient Safety
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	No	Yes	Population/ Public Health

[1] NQF 0031 is no longer NQF endorsed.
[2] NQF 0061 should be reported if the CPC practice site was able to obtain the MU Stage 1 measure in their ONC Certified EHR. NQF 0061 was not included in Stage 2 MU, therefore it is considered optional.

EXHIBIT 32: CPC PRACTICE ELIGIBILITY CRITERIA

1. A practice must be a primary care practice and as such:

   a) Provide the first point of contact for patients and ongoing care.

   b) Be led by a board-certified general practitioner, internist, family physician, geriatrician or advanced practice nurse (as allowed by state law).

   c) Composed of predominantly, but not necessarily exclusively, primary care providers, defined as one of the following: a physician who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine; a nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60% of allowed charges under the Physician Fee Schedule.

   d) Provide predominantly, but not necessarily exclusively, primary care services.

   e) May have multiple sites as long as these sites function as an integrated entity with centralized decision making, shared office space, facilities, clinical records, equipment, and personnel.
2. Have National Provider Identifiers (NPIs) and Tax Identification Numbers (TINs).
3. Be geographically located in a selected market.
4. Have at least 60% of their revenues generated by payers participating in this initiative.
5. Have a minimum of 200 eligible non-institutionalized Medicare beneficiaries, who are eligible for Part A and enrolled in Part B, but who are not enrolled in a Part C plan, Medicare Cost Plan, Demonstrations Plan, or PACE Plan, and who do not have end-stage renal disease (ESRD). Medicare must be the primary insurer for these beneficiaries.
6. Use an electronic health record (EHR) system or electronic registry.

EXHIBIT 33: CPC PAYER ELIGIBILITY CRITERIA

a) Payers must commit to enter into compensation contracts with primary care practices selected for the initiative. All practices selected must support the comprehensive primary care functions described in Section E. The method of enhanced, non-visit-based support proposed by payers must enable the primary care functions to be delivered at the point of care and integrated into the practice workflow.

b) Payers must commit to enter into compensation contracts with primary care practices selected for this initiative that includes the opportunity for practices to qualify for shared savings.

c) Payers must share with CMS their attribution methodologies.

d) Payers must be willing to provide participating practices with aggregate and member-level data about cost and utilization for their members receiving care from practices participating in the initiative, at regular intervals.

e) Payers must be willing to align quality, practice improvement and patient experience measures with the Innovation Center and other payers in their market for purposes of monitoring implementation milestones, quality improvement, and patient experience of care from practices participating in this initiative.

f) Payers must provide information on the markets in which they are interested in participating.

EXHIBIT 34: THINC* CPC YEAR 1 PRACTICE MILESTONES

Milestones	Pre APC	Standard	Premium
▪ Complete an annual budget forecast	✓	✓	✓
▪ Provide care management for high risk patients	✘	✘	✓
▪ Provide 24/7 patient access	✘	✓	✓
▪ Assess and improve patient experience of care	✓	✓	✓
▪ Use data to guide improvement at the provider/care team level	✓	✓	✓
▪ Demonstrate active engagement and care coordination across the medical neighborhood	✘	✘	✓
▪ Improve patient shared decision-making capacity	✘	✓	✓
▪ Participate in the market-based learning community	✘	✘	✓
▪ Attest to the requirements of Stage 1 of Meaningful Use for the EHR Incentive Program	✘	✓	✓

*Taconic Health Information Network Community

Appendix F. Stakeholder Outreach

OVERVIEW

New York's State Health Innovation Plan was created with the active input of multiple and diverse stakeholders that included and represented consumers, providers and payers. The State's multi-agency project team made a concerted effort to include stakeholders from a variety of perspectives so as to have a robust stakeholder process, as well as to generate conversation and excitement around NYS's plan. We actively engaged as many different populations and perspectives as possible including representatives of payers (Medicaid and commercial insurers), purchasers, providers, including the Medical Society of the State of New York, family practice physicians, nurses and nurse practitioners, hospitals, and federally qualified health centers. Consumers were engaged through numerous in-person meetings throughout the State as well as through stakeholder conference calls organized by coalitions. Four main methods of stakeholder outreach were used:

1) interviews and feedback sessions;
2) conference calls;
3) webinars;
4) multi-sector meetings and presentations.

Some of the presentations had strategic focus including the:

- PCMH Roundtable
- Population Health Summit
- United Hospital Fund Health Policy Forum Breakfast

The State's multi-agency project team travelled the State to several regions for in-person large stakeholder group meetings specifically on the Plan. At these meetings, the State sought direct input on the Plan, an understanding of the current initiatives in the regional communities, and input on how the state can assist each region in achieving the Triple Aim. The State worked closely with existing regional convening groups to ensure the broadest group of stakeholders would be included in discussions of the Plan. Attendees at these meetings included a very broad spectrum of stakeholders, including all of the categories listed below.

STAKEHOLDER CATEGORIES

The State met with many organizations and representatives throughout the development and refinement of the Plan. Here is a sample list of just some of the stakeholders:

Consumers: The state provided a presentation to multiple members of Medicaid Matters on an all-member call. Medicaid Matters New York (MMNY) is a

statewide, consumer-oriented coalition that advocates on behalf of New York's Medicaid program and the people it serves. MMNY includes a diverse set of more than 140 organizations united in their determination to ensure that the concerns and needs of Medicaid consumers are understood, included and met in any discussion on the state's public health insurance programs – Medicaid, Child Health Plus, and Family Health Plus. MMNY is unique in that it is the only organized, statewide coalition that speaks solely for Medicaid beneficiaries.

Specific to the State's outreach to the MMNY, many consumer organizations were present including: the Schuyler Center, Legal Aid Society, UJA-Federation, Association for Community Living, Medicare Rights Center, DD Alliance of WNY, Coalition of Voluntary Behavioral Health Agencies, NYers for Accessible Health Coverage, Harlem United, Family Planning Advocates, Community Health Care Association of New York State, Legal Services for the Elderly, MS Society, NY Self-Determination Coalition, NY Association on Independent Living, Community Service Society, ElderChoice and the Alliance of TBI/NHTD Waiver Providers, Women's City Club, Coalition of the Homeless, Public Health Institute, and the Center for Disability Rights.

The State also engaged Health Care for All New York (HCFANY) in its outreach efforts. HCFANY is a statewide coalition dedicated to winning affordable, comprehensive, quality health care for all New Yorkers. Founded in late 2007 with a Robert Wood Johnson Foundation "Consumer Voices for Coverage" grant, HCFANY came together under the leadership of eight organizations: The American Cancer Society, Center for Working Families, Community Service Society, Children's Defense Fund of NY, Citizen Action of New York/Public Policy Education Fund, Metro New York Health Care For All, New Yorkers for Accessible Health Coverage, and the New York Immigration Coalition.

Providers: Other external stakeholder outreach included meetings with representatives from existing medical home projects including the CPCi project in the Capital District and Hudson Valley, as well as the Adirondack Medical Home project in Northern NY. Provider associations, such as the Medical Society of the State of New York and the Mental Health Association, were also included in individual and group stakeholder meetings throughout the Plan's development and refinement. Additionally, many individual providers were included in in-person stakeholder meetings which occurred across the regions of NY.

The State also conducted numerous meetings with hospital associations including the Healthcare Association of New York State (HANYS), Greater New York Hospital Association (GNYHA) and specific hospitals themselves.

Additionally, medical schools and their associations were included in the stakeholder engagement process for the Plan as well.

Payers: A multi-agency project team including representatives of the Departments of Health, Financial Services and Civil Service met with a wide array of individual health plans as well the NYS Health Plan Association (HPA). Health plan meetings were launched in collaboration with the NYS Department of Financial Services (DFS) and were informed by a survey released by DFS to plans. These meetings were used to further explore responses to the DFS survey and garner initial reactions to the State's current thinking on the Plan. The following commercial plans were engaged in multiple calls and meetings throughout the process of developing the SHIP and will be engaged with the addition of other plans not captured below as part of taskforces convened to begin the implementation process.

- Aetna
- Amerigroup
- Capital District Physician's Health Plan (CDPHP)
- EmblemHealth
- Excellus
- Fidelis
- Healthfirst
- Health Now
- Independent Health
- MetroPlus
- MVP Health Care
- United Healthcare
- WellPoint
- Association of Blue Cross Blue Shield
- NY Health Plan Association (NYHPA)
- Coalition of New York State Public Health Plans (PHSP Coalition)

Purchasers: The State project team included the Department of Civil Service, which serves as the purchaser for State employee health benefits. In addition to this large employer and purchaser, the State met with the Business Council of New York State, as well as regional business groups (i.e., Northeast Business Group on Health) and employers (i.e., Wegmans Food Markets) included in our in-person stakeholder meetings.

Regional organizations: Due to the geographic diversity of NYS, the State project team worked closely with existing regional entities to convene appropriate stakeholder meetings in each region on the Plan. Groups that played a major role in bringing stakeholders together for each region include the P2 Collaborative of Western NY, the Finger Lakes Health Systems Agency, the Adirondack Health Institute, the Taconic Health Information Network and Community, and

HealtheConnections. As these regional organizations are well-experienced conveners in their respective regions, they supported the State tremendously in including the broadest outreach effort for engagement on the Plan. These regional conveners invited many additional other stakeholder types such as regional health information organizations (RHIOs), foundations, medical schools and universities, educational institutions, county health departments, legislative staff, local businesses, and coalitions in these meetings for discussion of the Plan.