ANNUAL REPORT: IMPLEMENTATION OF THE NY STATE HEALTH INNOVATION PLAN (SHIP)

January 2017

Contents

Introduction

Chapter 57 of the Laws of 2015 require the Commissioner of Health to prepare an annual report on the implementation of the State Health Innovation Plan (SHIP) including:

- The recommendations of the workgroups established to assist the state in implementation of the SHIP;
- The Department's efforts in advancing the SHIP's goals; and
- Information on the expenditures of the State Innovation Model (SIM) grant.

This report provides an update on the State's SHIP and State Innovation Model activities in 2016.

New York's State Health Innovation Plan (SHIP) is the roadmap to achieve the "Triple Aim" for all New Yorkers: healthier people, better care and smarter spending. 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.

To achieve the aspirations of the SHIP, New York State, in coordination with Health Research Inc., applied for and was awarded a four year, $100 million State Innovations Model (SIM) Testing grant from the Centers for Medicare and Medicaid Innovation (CMMI) with a start date of February 2015.
The first year of the four year grant was devoted to planning; operations are to commence in 2016. As part of the planning process, the Department launched a multi-agency, multi-sector governance structure to engage stakeholders representative of payers, providers and consumers in the development of the Advanced Primary Care (APC) model and its supporting components (value based payment, common metrics, and alignment with behavioral and population health) in preparation for implementation in the later part of 2016. In addition, an existing workgroup on Health Information Technology provided guidance and input on the Statewide Health Information Network of NY (SHIN-NY) and the All Payer Database (APD), both key components of the SHIP, and a workgroup of workforce was convened to provide input and guidance on emerging health workforce needs in New York State.

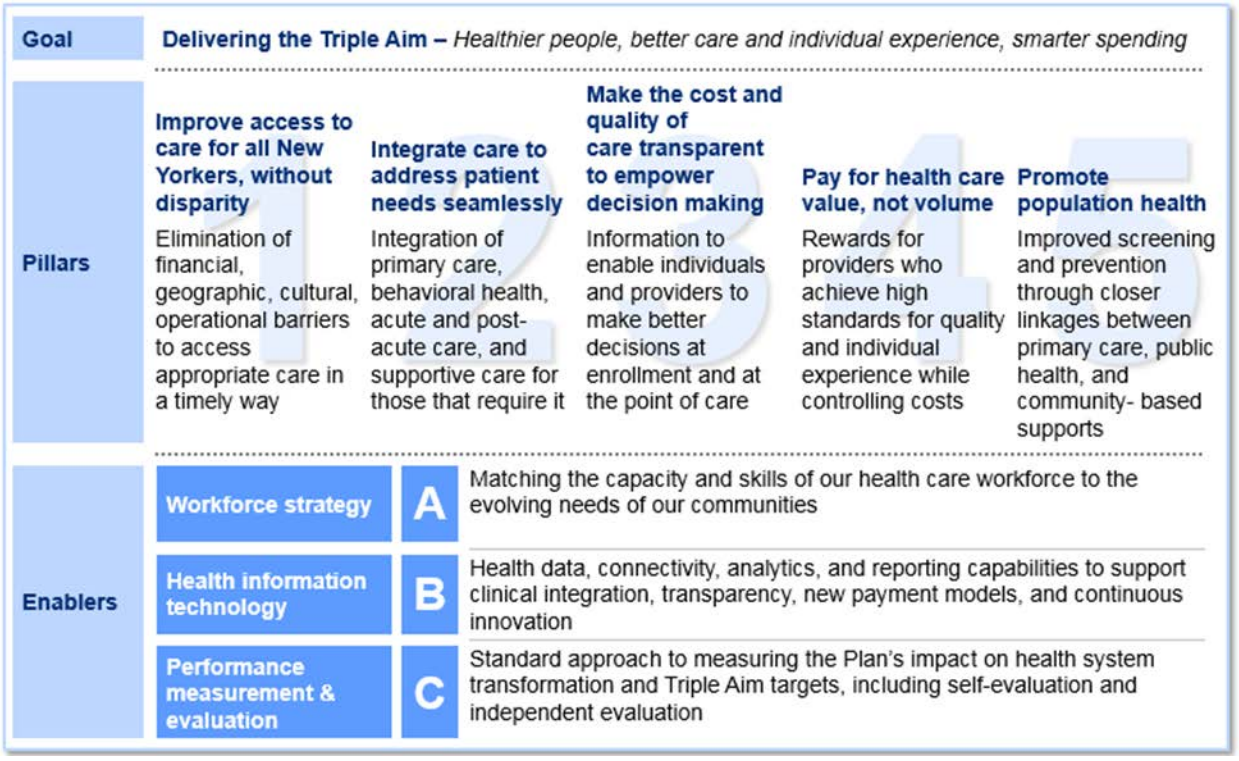
The goals of New York's SIM grant are to:

- Promote health and well-being through development, implementation and evaluation of an advanced primary care delivery model, together with alternative payment models, that promote care coordination and management, as well as enhanced integration with behavioral and population health and with long-term care and community support.
- Support performance improvement and primary care capacity by:
    - Expanding New York's primary care workforce through innovations in professional education and training;
    - Integrating primary care with population health;
    - Creation and common adoption of a core set of measures (a common scorecard) with shared quality metrics across multiple payers and providers;
    - Continuing to implement and support the State's All Payer Database (APD) and Statewide Health Information Network (SHIN-NY);
    - Supporting an independent evaluator, data collection, and performance monitoring; and

- Promote transparency to ensure that patients have access to information that will help them make informed choices about their health care and so that payers and providers have information that can be used to improve care and monitor expenditures and utilization.

Background

In December 2013, the NYSDOH, in partnership with other state agencies and external stakeholders, developed New York's State Health Innovation Plan (SHIP). The SHIP is New York's roadmap to achieve the "Triple Aim" for all New Yorkers: healthier people, better care and smarter spending. New York's health care delivery transformation plan, as articulated in the SHIP, is built on five pillars and three enablers:



The SHIP, recognizing that a lasting health delivery system reform requires a high performing primary care system, proposes statewide implementation of an enhanced medical home model, "Advanced Primary Care" (APC). Findings in New York and nationally suggest that a care delivery system with a medical home model at its heart is likely to achieve the Triple Aim. Thus, New York requested SIM funding to support the following:

1. Transformation entities to work with practices to help them evolve to meet APC capabilities including team-based care and outcome-based payments;
2. Programs to ensure an adequate workforce consistent with an evolved primary care delivery system;
3. Development of a set of aligned quality, utilization and cost measures that are consistent across payers and providers; and
4. Population health initiatives to ensure communication and integration of clinical and community-based providers to meet CDC and Prevention Agenda goals.

New York's plan builds on successes to date and incorporates lessons learned from an extraordinary range of initiatives, including the Aligning Forces for Quality (AF4Q) and Beacon Community initiatives in

Western NY, a large number of payer-supported medical home projects, including two regional, multi-payer medical home initiatives, and CMMI-funded Innovation initiatives, including the Finger Lakes HSA's Innovation Award. New York's Medicaid program has provided early leadership and ongoing support for the medical home model by including a major initiative to implement medical homes in physician practices across the state, in hospital teaching clinics, and, most recently, the Delivery System Reform Incentive Payment (DSRIP) program.

New York's State Innovations Model (SIM) grant represents an opportunity to leverage investments made to date to assure broad adoption of an Advanced Primary Care (APC) model inclusive of behavioral and population health, coupled with a strong workforce and educated and engaged consumers, supportive payments, and common metrics. More specifically, the major components of the model that have been developed include:

1. Capabilities that describe an Advanced Primary Care practice
2. Milestones that define specific expectations of a practice in terms of key capabilities and performance against core measures
3. Gates that define practice transformation achievements over time and inform payers regarding timing and purpose of prospective reimbursement
4. Core quality measures that reflect a practice's impact on patient health, quality of care, and experience across six domains
5. Initial design of a quality measure scorecard that will enable stakeholders to track and evaluate the progress of the SIM and APC, in improving the quality and cost-effectiveness of care in practices that are implementing advanced primary care models.

External Governance Model

New York's SIM governance is modeled on New York's successful Medicaid Redesign Team (MRT) structure to include an overarching policy team supported by topic-specific workgroups. The overarching team, the Health Innovation Council comprised of internal and external stakeholders, is charged with:

- Framing a cohesive policy agenda to advance the Triple Aim
- Providing guidance on key decision points and potential policy recommendations developed by topical workgroups
- Considering and offering guidance to support the consistency of vision, mission, metrics and incentives across key programs

Reporting to the Health Innovation Council are three topic-specific workgroups as outlined below. All workgroup meeting materials are posted on the NYSDOH public website at the following link - https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm.

1. Integrated Care Workgroup

Goal: Promote health and well-being by supporting innovation in primary care.

Charge: The Integrated Care Workgroup (ICWG) was developed to engage payers, clinicians, and consumers in the development of the Advanced Primary Care (APC) model and its supporting components. The ICWG's charge had four main elements:

- Create a vision for Advanced Primary Care (APC) that promotes the coordination of care for patients across specialties and care settings, improves patient experience and clinical quality, and reduces avoidable costs.
- Align measurement across payers to accelerate improvement efforts, promote consistency and parsimony, and support provider and payer focus on a key set of meaningful measures.
- Provide guidance on how to best develop statewide primary care practice improvements, and alternative payment strategies.
- Catalyze multi-payer (including commercial, Medicaid, and Medicare) investments in primary care practices; initial investments in achieving a higher-performing primary care system, and payment change to recognize and support the increased operating costs of this high-value model; and to ensure aligned incentives and supports necessary to achieve the Triple Aim.

2. Transparency, Evaluation, and HIT Workgroup

Goal: Assure implementation of health information systems necessary to support and inform transformation.

Charge: Evaluate the state's health information technology infrastructure and systems as well as other related plans and projects, including, but not limited to, the All Payer Database (APD), Statewide Health Information Network of New York (SHIN-NY) and State Planning and Research Cooperative System (SPARCS).

- Develop recommendations for the state to move toward a comprehensive health claims and clinical database to improve quality, efficiency and cost of care, and patient satisfaction.
- Design and implement/manage standardized, consistent approaches to measure cost and quality to support evaluation of the Plan's impact on system transformation and Triple Aim goals and objectives.
- Provide expert guidance on an APC scorecard for Triple Aim.

3. Workforce Workgroup

Goal: Promote a New York State health workforce that supports comprehensive, coordinated and timely access to care that encourages health and well-being. Make recommendations to the Health Innovation Council and the DSRIP Project Approval and Oversight Panel regarding workforce needs in order to support the development and promotion of integrated care delivery that will ultimately result in health improvement.

Charge: This workgroup is charged with promoting New York's health workforce to support its transition to integrated health care delivery including an Advance Primary Care practice model to assure comprehensive, coordinated and timely access to care. Emerging priority areas of focus have been identified:

- Ensure sufficient primary care workforce.
- Better distribute primary care workforce to areas of need.
- Make the most effective use of the health care workforce under the new model.

- Improve the supply and effectiveness of behavioral health workforce.
- Train workforce for team-based care.
- Shift mindsets among the health care workforce.
- Improve data collection regarding health care work force.

The Workforce workgroup developed five subcommittees in 2016 to address the complex challenges affecting New York State's health workforce. This work is detailed in the next section.

Internal Governance

The Model Test is led by the Division of Health Care Innovation in the NYSDOH Office of Quality and Patient Safety (OQPS), hereafter referred to as the "Innovation Center". The Division is accountable for completing deliverables, supports the day-to-day operations of the SIM cooperative agreement, and facilitates work in other areas of NYSDOH and with partner agencies. The Innovation Center also coordinates with the Executive Chamber and NYSDOH executive leadership on critical decisions to ensure that SIM work moves forward.

A multi-agency Health Integration Team ensures coordination across program areas within the NYSDOH and partner agencies. The Health Integration Team membership also includes Department of Health staff responsible for the implementation of CDC-funded chronic disease grants, including tobacco control, diabetes, heart disease, obesity prevention and control, and cancer prevention and control. These linkages are essential for success in transforming health and health care across all of New York, including both commercial and public payers.

Progress in Strategic SIM Topic Areas

The implementation of the SIM cooperative agreement includes several priority issue areas that tie directly back to the pillars and enablers of the SHIP. The topic areas and the progress made in each of these strategic initiatives follows:

- Integrated care through APC
- Health information technology
- Population health
- Workforce
- Access to care
- Evaluation

INTEGRATED CARE THROUGH ADVANCED PRIMARY CARE

APC Design

New York's SIM initiative will invest significant federal resources ($67M over three years) to assist primary care practices in transforming to a highly integrated, team-based care model that is inclusive of care management, as well as alternative payments models that promote and incent outcome-based reimbursement.

The APC model describes enhanced capabilities, processes, and performance of primary care providers based on lessons learned from the Comprehensive Primary Care initiative (CPCi), Multi-payer Advanced Primary Care Practice (MAPCP) program, and NCQA Patient Centered Medical Home (PCMH). Each of these initiatives is premised on primary care assuming a central role in coordination of care to achieve optimal health and well-being of their panel of patients, in collaboration with patients themselves.

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

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

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

1. Capabilities that describe an Advanced Primary Care practice (Figure 1), including patient-centered care, population health, integrated behavioral healthcare, care management, access to care, health Information technology (HIT) enabled systems, alternate payment model and quality and performance
2. Milestones that define specific expectations of a practice in terms of key capabilities and performance against core measures (Figure 3)
3. Gates that define practice transformation achievements over time and inform payers regarding timing and purpose of prospective reimbursement (Figure 2)

4. Core quality measures that reflect a practice's impact on patient health, quality of care, and experience (Figure 4) across six domains: prevention, chronic disease, behavioral health/substance use, patient-reported outcomes, appropriate use, and cost
5. Initial design of a quality measure scorecard that will enable stakeholders (clinicians, payers, consumers, and the state) to track and evaluate the progress of the SIM and APC, in improving the quality and cost-effectiveness of care in practices that are implementing advanced primary care models.

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

Figure 1: APC Practice Capabilities

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

Figure 2: APC Gates

Figure 2 outlines the journey for practices in their evolution through APC, as they advance through three "gates" defining graduated levels of practice infrastructure and capacity.

Gate 1: Commitment and preparation

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

Gate 2: Readiness for care coordination including payment

- Reaching Gate 2 indicates a practice's readiness to provide effective care coordination. Necessary capabilities at this point include:
  - The ability to identify high-risk patients and successfully measure and report the Core Measures derived from practice data.
  - Capacity to provide care coordination for high-risk patients within one year.
  - Infrastructure and commitment to use results from APC Core measures for improvement.

Gate 3: Demonstration of APC capabilities and performance

- One year after meeting Gate 2 (or sooner if ready), practices will have to demonstrate active care management and coordination for a majority of their high-risk patients. At this point,

they will be required to connect to their regional health information exchange (RHIO). Importantly, demonstrating APC capabilities implies moving from an ability to measure performance to the ability to demonstrate improvements in quality and reduced preventable costs.

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

Figure 3: APC Structural Milestones

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

Figure 4: Core Measures

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

Figure 1. APC Practice Capabilities

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Figure 2. APC Gates

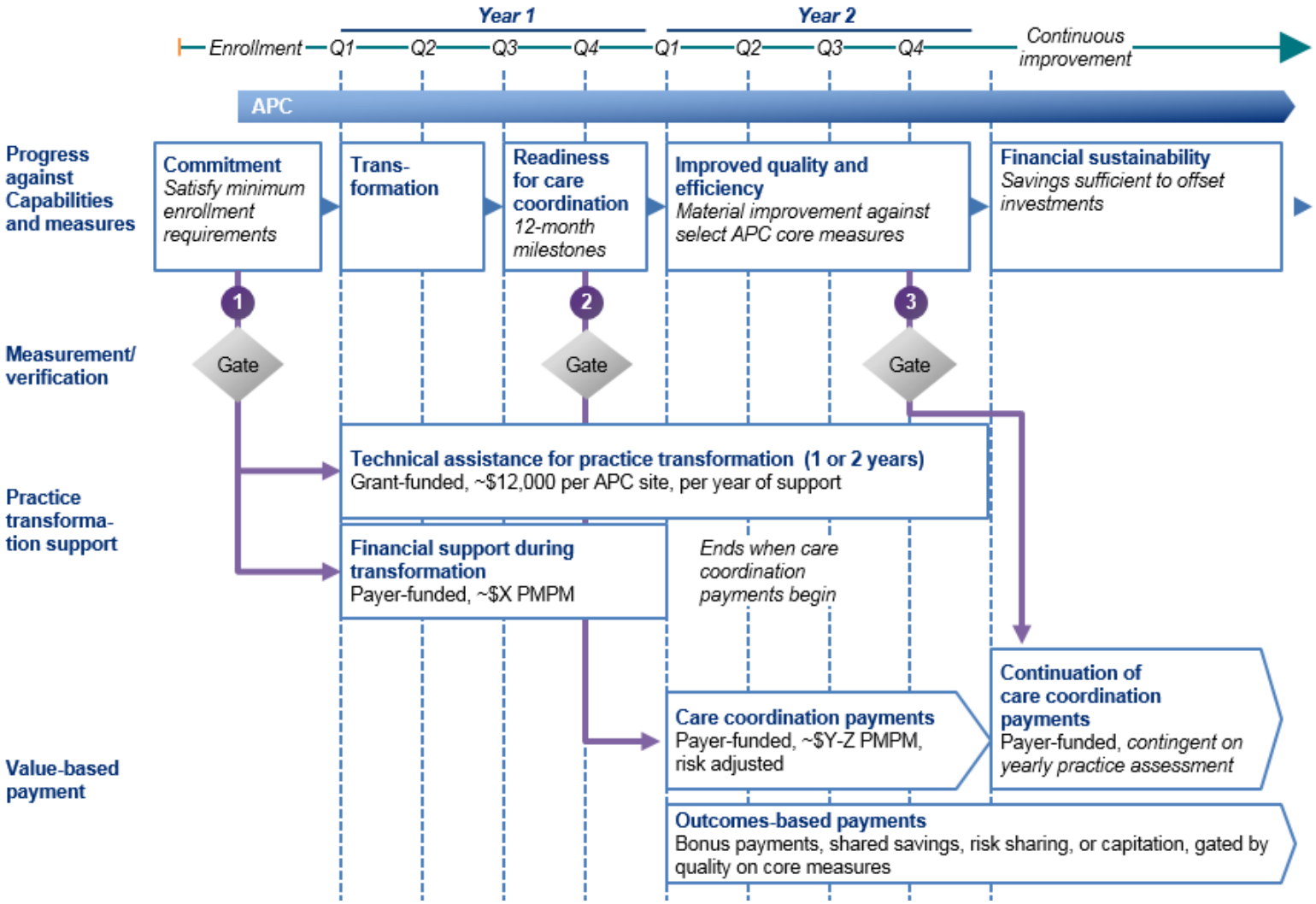


Figure 3. APC Structural Milestones

	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet* **Prior milestones, plus …**	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination* **Prior milestones, plus …**
Participation	i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	i. Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year	i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
Population health			i. Participate in local Prevention Agenda activities ii. Annual identification and outreach to patients due for preventive or chronic care management iii. Process to refer to self-management and community-based resources
Care Manage-ment/ Coord.	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year	i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework

Figure 4. APC Core Measures

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

Practice Transformation to Support APC

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

In 2016, the Department with Health Research., Inc. released an RFA[1] requesting proposals from vendors of primary care practice transformation technical assistance across different regions of the state. Funded contractors will be expected to assist practices and providers to develop the systems and processes necessary to meet the goals of the Triple Aim. Contracts are being executed and transformation agents are beginning their work.

To ensure full coverage of the State and to make additional support available to practices, the Department and HRI released the Practice Transformation RFA a second time in December 2016. Additional contracts will be awarded in early 2017.

Engagement of Health Plans

APC development has engaged payers – including commercial health plans and employers/purchasers in self-funded arrangements – as part of the foundational developmental work through multi-payer meetings and one-on-one consultations with payers. The Department and the Department of Financial Services (DFS) completed an initial effort to request, receive, and analyze information from health plans in the State of New York regarding initiatives to support primary care transformation and expand payment innovations[2]. Major findings included: Every plan identified at least one alternative or outcome based program, and a majority of plans currently provide some level of practice transformation support (either financial or technical support) to certain practices deemed ready for the introduction of advanced primary care services.

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

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

[1] Practice Transformation RFA: https://www.healthresearch.org/rfarfp-rfa-qps-2016-02/
[2] The payer Request for Information is available at the following link, with supporting material on the ICWG page: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/apc_payer_information_request.pdf

the state and directed to employers and health plan executives.

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

- While the state's health plans are generally supportive of the state's APC initiative and the medical home model, many already have some programs in place to recognize and reward primary care practices and/or ACOs using a variety of 'value-based payment' approaches.

- There is substantial heterogeneity among payers in the primary care delivery models they currently favor including which quality measures and value-based payment models they pursue.

- The state should consider ways to incentivize plans to continue to support primary care programs and APC.

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

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

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

APC COMMON SCORECARD

A comprehensive and systemic set of indicators has been developed to allow benchmarking against national results for use by APC participating practices. The proposed measure set reflects nationally recognized measurement approaches, such as NCQA's Healthcare Effectiveness Data and Information

Set (HEDIS), National Quality Forum (NQF), and CMS' Children's Health Insurance Program Reauthorization Act child and adult core sets, which can be used across various payers, providers and regions of the state. These indicators have been developed through extensive consultation with internal and external experts and stakeholders. The proposed core measure set is depicted in Figure 4, above.

With an agreed upon set of common metrics, the next task is to create a mechanism for collecting and sharing this key information in advance of a fully functional All Payer Database (APD). To ensure implementation of APC and the required metrics, New York is currently engaged in conversations to secure assistance with data collection and sharing this data back with payers, providers and the State. In the interim period prior to the APD completion, results for measures will be provided through member detail files from health plans. The Department issued a survey to a sample of health plans requesting their participation in gathering information about insurers' ability to provide quality measure results for aggregation to APC practices. Survey results facilitated the development of the details for providing the member detail files. In the fourth quarter, a pilot with five health plans tested production and submission of member detail files which will be used for the preparation of APC Scorecards for practices in 2017.

HEALTH INFORMATION TECHNOLOGY (HIT)

New York State has a substantial heath IT infrastructure that includes the Statewide Health Information Network of New York (SHIN-NY), a developing All Payer Database (APD), as well as existing resources, such as SPARCS. These information systems provide benefits to many audiences and are integral to success of the APC model. Some benefits include the ability to calculate total costs of care across the practice, be able to best manage patient care through tools such as hospitalization alerts, and better track referrals and follow-up. The Transparency, Evaluation, and HIT Workgroup (HIT WG) was convened to assess and make recommendations regarding policies and initiatives that comprise the State's evolving health information technology infrastructure.

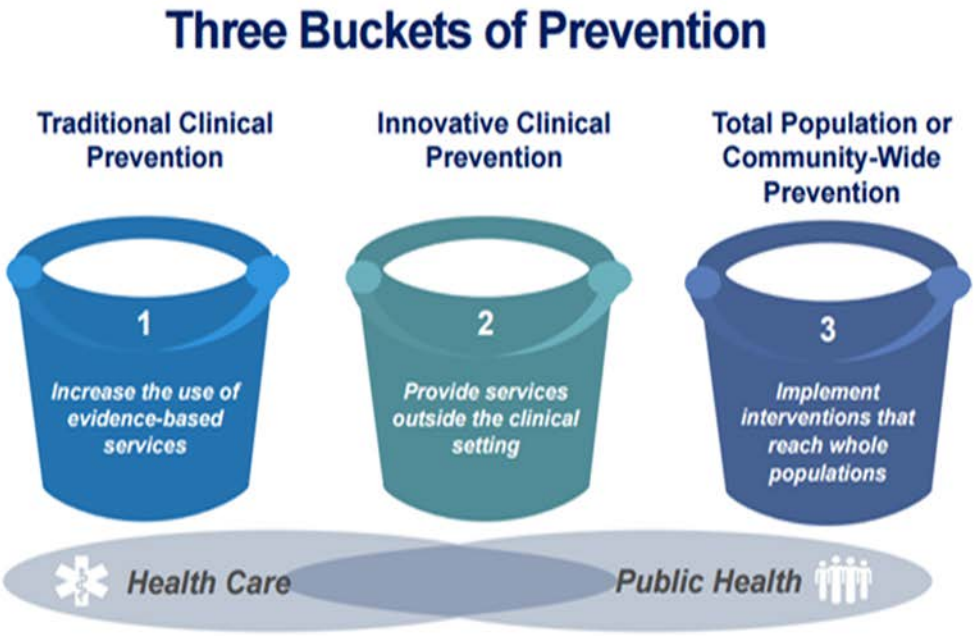
Over the past year, the HIT WG considered and provided expert input to NYSDOH to develop APD regulations. In addition, evolving initiatives to promote transparency, protect patient level data and to develop a common quality of care measure set meaningful to payers and providers alike have been discussed. The HIT WG will play a role in informing the implementation of the APC Scorecard in the next year.

POPULATION HEALTH

New York's SIM is predicated on an integrated care delivery model that is inclusive of and supports linkages between clinical care providers and community-based organizations in order to achieve the goals and objectives of New York State's Prevention Agenda. Population health is directly integrated in the APC model – practices will be charged with identifying and reporting on at least one region-specific Prevention Agenda metric and New York's core measure set includes several practice-level population health measures.

In 2016, the Department issued a Request for Applications: Linking Interventions for Total Population Health ("LIFT Population Health") and received 27 applications.[3] LIFT Population Health will fund community coalitions to come together around one chosen Prevention Agenda issue and includes primary care practices. These primary care practices do not have to participate in any specific health care reform initiative or receive assistance from a practice transformation agent in order to participate. The Department will strongly encourage LIFT awardees to include practice transformation agents that are working in their region in their coalition and prevention efforts.

CDC's Three Buckets of Prevention



Auerbach J., The 3 Buckets of Prevention. Journal of Public Health Management and Practice 2016.
http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx

These community-based projects will bring together key sectors, including but not limited to local health departments, health care providers, health care payers, primary care practitioners, community based organizations, schools, advocacy groups, employers, and academia to collectively advance a common health priority consistent with NYS's Prevention Agenda.

Projects will focus on one of the five issues related to the Prevent Chronic Disease priority area of the Prevention Agenda. Awardees will focus their efforts on the integration of all three buckets but their level of effort will be significantly higher across Bucket 2 (30 percent) and Bucket 3 (60 percent), as there are already significant activities funded and underway in Buckets 1 and 2 through DSRIP and the APC model. Projects will leverage existing resources and will build upon and enhance previous work carried out by awardees and their partners and will advance a shared agenda for prevention of chronic disease and healthy communities.

[3] https://www.healthresearch.org/wp-content/uploads/2016/08/QPS-2016-04-Population-Health-RFA-FINAL-2016-8-4-16.pdf

While population health does not have its own SIM workgroup, a number of population health representatives serve on the other SIM workgroups to ensure integration of population health within other areas of focus. Staff working in the Office of Public Health work with the SIM team to ensure alignment of efforts and integration of population health, and will together rollout LIFT awards in 2017.

WORKFORCE

New York's robust health care workforce faces future challenges including regional variation in workforce supply, primary care workforce shortages, hospital downsizing, and an aging workforce. To prepare for 2016 work, a comprehensive workforce needs survey was distributed to members of the Workforce Workgroup to identify priorities of focus for the group. The identified priorities included:

- Promote the ability of New York's health workforce to function effectively and help support emerging models of care and changes in the health care delivery system;
- Promote the development of a sufficient supply of primary care providers;
- Promote development of a sufficient supply of behavioral health providers;
- Enhance the effectiveness of the current workforce;
- Address the maldistribution of providers to deliver behavioral health services; and
- Address the maldistribution of providers to deliver primary care.

The Workforce Workgroup has convened five subcommittees to address these priority areas. Much of the activities of the Workforce Subcommittees to date have focused on care coordination. Care coordination has been afforded much attention because it impacts most of the identified priority areas; is patient and family centered; it involves all professionals on the health care delivery team in the clinical setting; it improves patient health outcomes, the efficient use of workforce resources and the effectiveness of care; and it addresses the inability of the health care delivery system to effectively and efficiently carry out care coordination functions in a primary care-focused, networked, team-based and value-driven delivery system required for APC.

Following is a description of each of the five Subcommittees, their activities, achievements and future goals.

Subcommittee 1: Identifying Barriers to Performance of Care Coordination Functions

Subcommittee #1 is reviewing the scope of care coordination functions carried out by licensed and non-licensed workers as well as non-licensed family and friends, to identify barriers that are related to the scope of practice of members on the care delivery team. The subcommittee has concluded that the scope of practice for licensed professionals generally does not preclude them from carrying out tasks related to care coordination, although there are some barriers (e.g., because licensed practical nurses are supervised by registered nurses, they cannot carry out some tasks on their own whereas such tasks can be performed by unlicensed individuals).

The Subcommittee is also discussing the role of community health workers, who assist individuals in adopting healthy behaviors, help community residents communicate with health care providers and social services agencies, conduct outreach and implement programs to improve individual and community health.

In 2017, Subcommittee #1 will prioritize the extensive and complex statutory and/or regulatory barriers that are related to scope of professional practice and/or to payment and identify opportunities for healthcare professionals to work at the top of their certifications and licenses.

Subcommittee 2: Recommending Care Coordination Concepts for Licensed Practitioners

Subcommittee #2 is working to identify core concepts in care coordination that can be recommended for inclusion in the educational curricula for licensed professionals. The membership of this Subcommittee is comprised of deans of medical, nursing, and other health care professional schools and leaders of professional and trade associations who can facilitate achievement of the goal. Subcommittee #2 has been assessing the extent to which care coordination concepts already exist in the curriculum for training physicians and other health care professionals and has determined that approximately two-thirds of New York State medical schools report covering some type of care coordination in their curricula, although there is some variation in content.

Next year, this work will continue, with the ultimate goal of identifying and recommending core care coordination concepts for use by education and training institutions. Incorporation of these concepts will be recommended to promote consistency across institutions and professions.

Subcommittee 3: Developing Core Curriculum Guidelines for Care Coordination

The Workforce Workgroup has recognized the need to identify consistent training guidelines for workers who carry out care coordination functions and charged Subcommittee #3 with developing such guidelines. As a result, this Subcommittee reviewed literature on care coordination training available from various sources throughout the country and curricula in use by different training entities across the state. Using the training content drawn from these sources with the most overlap, the Subcommittee identified key concepts to serve as the basis for developing core curriculum guidelines for training workers who provide care coordination. These core curriculum guidelines consisting of nine modules, have been used extensively by PPSs and other health care delivery organizations to train their current staff, and are available on the Department's website.[4]

As a result of this work, the Subcommittee completed its assigned charge, and was retired. In the future, the group may re-convene periodically to revise and update the guidelines to incorporate new concepts as deemed necessary.

Subcommittee 4: Addressing Gaps in Health Care Workforce Data

The Workforce Workgroup observed that there is insufficient information available about the health care workforce, particularly with respect to the distribution of practitioners throughout the State. The Workforce Workgroup charged this subcommittee with identifying gaps in available information about the health care workforce and recommending strategies to enhance data collection and workforce planning capabilities.

[4] https://www.health.ny.gov/technology/innovation_plan_initiative/docs/core_curriculum_train_ccw.ppdf

The New York State Physician Profile is a publicly available online resource that provides information about individual licensed physicians. Subcommittee #4 recommends a statutory change to support the collection of additional information from physicians through the Physician Profile for workforce planning purposes. The additional data elements would be excluded from the public profile where appropriate.

The subcommittee also noted that some data is available on a small number of professions through voluntary surveys as part of professional registration. However, response rates vary and information is not sought from all health care practitioners. As a result, the Subcommittee recommends adopting a data collection approach recently implemented for nurse practitioners. This would require a statutory change requiring all health care practitioners to provide information through brief surveys completed upon registration and re-registration with the State Education Department. The information would be based on federal Minimum Data Set guidelines and focus on key demographic, educational, and practice characteristics. The information would be used for health care workforce research and planning with de-identified, aggregate information made available on the DOH website.

Subcommittee 5: Behavioral Health Workforce Workgroup Subcommittee

Subcommittee #5 is devoted to the behavioral health workforce and will address the unique challenges facing expansion of integrated behavioral health care. Integrated behavioral health services offer an evidence-based, cost-effective strategy for overcoming many of the current system constraints, bringing behavioral health services to scale in primary care settings. There is growing momentum nationwide, and in New York State, to adopt integrated delivery models as part of DSRIP, APC, and the New York State Collaborative Care Program. In order for these programs to continue to spread and be successful, an appropriately skilled workforce needs to be available.

This Subcommittee plans to develop recommended training guidelines that incorporate elements of counseling using evidence-based techniques such as motivational interviewing, behavioral activation, and problem-solving, for staff in primary care to improve management of behavioral health; and develop a template curriculum for the role of Behavioral Health Care Manager, a critical role for the successful integration and expansion of behavioral health.

Subcommittee #5 is in the process of recruiting members to participate on the subcommittee and will be meet in early 2017.

Other Ongoing Workforce Activities

In addition to the activities of the five subcommittees, other SIM initiatives to address the workforce priorities identified by the workgroup have been undertaken.

New York is faced with a critical physician shortage in rural communities. To help alleviate the rural physician shortage, SIM funding has been allocated to support the development of four rural-based, accredited, Graduate Medical Education (GME) programs. A Request for Proposals (RFP) for funding the new GME programs have been published and contracts are in the process of being awarded at the time of this report.

The SIM-funded GME programs will create new opportunities for medical school graduates to train in under-served rural areas of New York, and provide and sustain a pipeline for the supply of future rural

practice physicians in primary care. The programs build competencies that prepare medical residents to deliver care in a multidisciplinary, team-based, value-driven, primary care focused setting, and greatly enhance the State's ability to achieve APC an enhanced model of primary care across New York. The programs also improve access to care and achievement of population health improvement outcomes.

New York's activities to transform its health workforce are ongoing. The diverse stakeholder Workforce Workgroup continues to drive the SHIP's workforce transformational efforts by setting the future direction, establishing the priorities and determining the measures of success.

ACCESS TO CARE

Under SIM, New York seeks to bring together key stakeholders, evaluate access from four key perspectives and develop a set of policy recommendations intended to eliminate barriers in accessing care, including those that are financial, geographic, social, and cultural in nature. While access to care was envisioned as having its own topical workgroup, discussions are underway to determine if a subset of another workgroup would be more feasible in order to avoid duplication of efforts and ensure better integration of access issues across the other existing workgroups. Key measures of access have been incorporated as part of the APC core measure set.

An area of focus in 2016 will include funding projects to support increased access to advanced primary care through Project ECHO (Extension for Community Healthcare Outcomes). This is a proven model that connects primary care practices with academic institutions to advance practice expertise in treatment and management of complex health conditions. A competitive procurement will be issued in early 2017.

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

EVALUATION

The Innovation Center continues to use traditional project management tools to ensure efficiency, goal attainment and course correction as needed. To ensure continuous improvement and impact of the SIM initiative, resources are being used to fund an external evaluation contractor to evaluate the NYSDOH's implementation of its goals under SIM. At this time, the SIM-funded evaluation will address the following evaluation questions:

- Potential Process Evaluation Questions
    - What is the value added of SIM?
    - What efforts are unique to SIM?
    - How did it accelerate existing efforts?
    - To what extent is NYS meeting its SIM targets?
- Where are the successes and gaps?
- What factors (program, policy, and environment) are relevant to successes/gaps?

    - What are the processes for implementation (moving from model and/ or concept to practice) and what have been the facilitators and impediments to those processes?
- In what ways and for what reasons has implementation varied? (e.g., regional distinctions, stakeholder buy-in)
    - What is the level of engagement/buy-in from different stakeholders, including providers, payers, community, and policy makers?
- What factors affect level of engagement?
    - What are the most notable successes to date?
- What factors explain the successes?
- What have been the key challenges?
- What factors explain the challenges?
    - Have there been unintended consequences (positive or negative)?
    - How effectively is the SIM addressing population health?
    - What role has technical assistance played in SIM implementation, its success and challenges?
- SIM/SHIP Component Parts
    - What progress has been made in specific strategic areas?
- Potential Outcome and Cost Evaluation Questions
    - To what extent and in what ways has quality of care improved?
    - To what extent and in what ways has health care utilization changed?
    - What progress is being made with respect to improved coordination of care?

The evaluator was onboarded in the last quarter of 2016, and will conduct a rapid-cycle evaluation of the SIM project and its components, including the APC model, workforce initiatives, and value-based payment arrangements. The New York Academy of Medicine (NYAM) will examine the overall impact of the New York SIM model, the effectiveness of policy and regulatory levers, and determine which program characteristics, implementation approaches or adaptations, and contextual factors are associated with better outcomes and reductions in costs. NYAM proposed to use the Plan-Do-Study-Act (PDSA) framework to guide its work. The rapid cycle evaluation will involve testing small scale changes, learning from these tests, refining the change via PDSA cycles, and considering the adoption of these tested changes within and across NYS regions.

Expenditures

The SIM grant award year runs from February 1, 2016 through January 31, 2017. The following is a breakdown of the categorical expenses from February 2016 through December 20, 2016.

Category	**Award to Date Expenses**
Salaries	$1,100,307.85
Fringe Benefits	$398,370.49
Equipment	$0.00
Supplies	$5,036.00
Travel	$12,024.23
Services	$12,348.70
Contractors	$4,518,192.80
Miscellaneous	$8,100.36
Indirect Costs	$355,834.84

Conclusion

Year two of the SIM cooperative agreement focused on the following:

- Preparation of implementation of the APC model, including the procurement of practice transformation services, and Payer Engagement in value-based payment models discussions
- The identification of workforce goals and objectives, and recommendations to support new initiatives
- Continued work to develop the SHIN-NY and APD
- Identification of key access to care concerns

Year three of the grant (2/1/17-1/31/18) will focus on the statewide operationalization of practices engaging in APC transformation and the first steps of actualization of value-based payment models. The Innovation Center will continue to engage stakeholders throughout the process to ensure support for this initiative and to promote alignment with other transformation efforts across the State.