IMPLEMENTATION OF THE NEW YORK STATE HEALTH INNOVATION PLAN

Annual Report: 2017

EXECUTIVE SUMMARY

The mission of the New York State Health Innovation Plan is to achieve the "Triple Aim" for all New Yorkers: better care, better health, lower cost. Each year, the Annual SHIP Implementation report provides an update on progress towards this goal.

Four years ago, the New York State Department of Health, Department of Financial Services, Department of Civil Service, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services worked collaboratively across agencies to develop the State Health Innovation Plan, an ambitious five-year plan to transform New York's health care system. At the time, a wide variety of barriers to improving care were noted, including:

- providers were rewarded for delivering more care, supports or services, whether that care was needed or not;
- consumers and their families were largely left on their own to navigate a fragmented system of providers;
- consumers and their families made health care decisions with little information, or sometimes were not actively involved in decisions made for them;
- health care was delivered separate from, rather than in concert with, population health improvement and local health planning;
- providers delivering high-quality care, supports or services saw no financial benefit to doing so and may in fact have been financially disadvantaged for doing so; and
- health care providers and services, particularly primary care providers, were not evenly distributed throughout the State and distribution did not necessarily follow need or demand.

Significant progress was made to overcome these barriers over the course of 2017, moving New York closer to achieving the promise of the SHIP. Accomplishments include: (1) the launch of the New York State Advanced Primary Care Model in February 2017; (2) 558 primary care practices that have begun the process of practice transformation since the launch, transitioning care delivery from that based on volume to care delivery based on value; thus (3) increasing the capacity of primary care physicians to deliver integrated care to patients while engaging patients in decisions about their care.

Additionally, Regional Oversight Management Committee's in the Capital District/Hudson Valley, Metropolitan, and Finger Lakes areas were convened to develop regionally specific multi-payer models. Commercial payers, providers, patients, and stakeholders participate in ROMCs to financially incentivize value-based care. Four Project ECHO contracts were awarded to increase

the clinical workforce capacity to provide best-practice specialty care and reduce health disparities in underserved areas.

This annual report details the progress made towards achieving State Health Innovation Plan goals in the 2017 program year. Four sections describe the:

- background on the State Health Innovation Plan and the State Innovation Model;
- recommendations from workgroups and committees governing the State Health Innovation Plan;
- reports on progress towards achieving State Health Innovation Plan goals; and
- a report on State Innovation Model expenditures.

SECTION I: BACKGROUND

The State Health Innovation Plan[1]

The SHIP is New York's vision to achieve the "Triple Aim" for all New Yorkers: better care, better health, lower cost. The SHIP is a multi-faceted approach that integrates care across all parts of the health care system including behavioral and community health. The central mechanism for achieving SHIP goals is an advanced primary care model that creates a clear path to health care transformation for New York State payers, providers, and patients.

Through the SHIP, New York State set three broad and ambitious goals to achieve within five years (2015-2020):

- achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement by 2020;
- achieve high standards for quality and consumer experience, including at least a 20% reduction in avoidable hospital admissions and readmissions; and
- 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.

Historically, New York State agencies, health care advocates, and federal laws have defined multiple and diverse pathways to transforming and improving health care. Under SHIP, these diverse initiatives are incorporated into a coordinated plan to accelerate health care transformation in NYS. The overarching premise of the SHIP is the belief that "Advanced Primary Care", a patient-centered medical home model that provides patients with timely, well-organized and integrated care, is the foundation for a high performing health system. The APC[2] supports overarching SHIP goals, specifically supporting three core objectives that NYS hopes to achieve within five years, namely that:

- 80% of the population is cared for under a value-based financial arrangement;
- 80% of the population receives care within an APC setting with a systematic focus on prevention and coordinated behavioral health care; and
- full transparency about the cost, quality, and access to care which enables informed choices by consumers and the public.

[1] The full State Health Innovation Plan is available on the New York State Department of Health website.
[2] New York's Advanced Primary Care model is detailed on p. 7-15 of the Integrated Care Workgroup Final Report.

New York State Innovation Model

NYS applied for a Model Testing Grant through the Center for Medicare and Medicaid Innovation in September 2012.[3] The application detailed specific initiatives to transform the health care system in New York State organized under the SHIP. NYSDOH was awarded a $99.9 million Round Two Model Test Award SIM grant by CMMI to implement and support SHIP activities in December 2014.[4] The overarching purpose of the SIM grant is to test the ability of the State to use regulatory and policy levers to accelerate health care transformation through APC and related initiatives.[5] The performance period for the grant runs from February 1, 2015 through January 31, 2019. A No-Cost Extension for the project was received in 2017, extending the project period through January 31, 2020.

While the implementation of the SHIP relies on the concerted efforts of multiple State agencies and stakeholders, SIM-funded activities are overseen by the Office of Quality and Patient Safety. Within OQPS, the Division of Health Care Innovation coordinates SHIP activities, as well as overseeing and implementing the SIM award.

SHIP Transformation Roadmap

The SHIP transformation roadmap recognizes the importance of good governance to ensure concrete project timelines, measurable achievement milestones, and fiscal responsibility for both SIM and SHIP. This report provides an overview of progress and outcomes from each of these areas. An overview of the governance structure for SHIP activities is detailed below.

Governance: Governance of SHIP activities is based on four foundational elements:

(1) Interagency coordination

NYS is one of the few states that has public health, Medicaid, and an Office of Quality and Patient Safety integrated within a single Department of Health. SHIP relies on interagency coordination across these areas, and also extends beyond traditional health boundaries to engage other stakeholder agencies, including DFS, DCS, DOB, OMH, and OASAS. The SHIP was designed to harness the unique expertise of each of these agencies to lead initiatives and work together. The SHIP also detailed clear and transparent departmental accountability for specific initiatives across these diverse stakeholders to ensure success.

(2) Public-private collaboration

Key stakeholders – payers, health care providers, purchasers, consumer advocates and other key organizations representing the health care industry – are pivotal to SHIP success.

[3] NYSDOH published the Round 2 SIM application on their website.
[4] More information about CMMI and the SIM initiative is available on the CMS website.
[5] The SIM grant application narrative and application summary are available on the public NYSDOH website.

Strong, formal mechanisms for these stakeholders to inform the direction and progress of SHIP include:

- an overarching Innovation Council
- three subject specific workgroups:
  - Statewide Steering Committee
  - Health Information Technology, Transparency, and Evaluation
  - Workforce Workgroup
- four ROMCs

(3) Regional input and tailoring

ROMCs provide a direct channel for regions across NYS to inform SHIP activities. ROMCs are regional consensus development entities supported through SIM funding. ROMC members include payers, providers, patients, and other stakeholders in health care delivery. ROMCs organize themselves, and the structure of their work, in a manner consistent with local health care cultures, payer mix, primary care needs, regional populations, consumer needs, concurrent initiatives and unique resources that characterize New York's diverse regions. A longstanding ROMC entity in the Adirondacks served as a model for ROMC development in other regions, including the: Capital District/Hudson Valley, New York Metro area, and Finger Lakes. In addition to informing the structure and governance of the three newer ROMCs, the Adirondacks ROMC continues to contribute to SHIP governance through participation in the Statewide Steering Committee and Health Innovation Council.

ROMC roles, functions, and goals are clearly defined in a charter developed by each group. As voluntary, consensus-based entities ROMCs do not have binding authority on any participating organization. They are member-led as opposed to state-led. OQPS provides a point person to assist each ROMC with oversight, organization, collaboration and coordination across agencies. This point person also acts as a liaison to SHIP workgroups. The presence of the point person at ROMC meetings that are "payer only" allows the groups to remain in compliance with NYS antitrust laws.

The broad goals of each ROMC are to:

- ensure the success of the APC model of care and payment reforms within their region;
- guide regional and community priorities to provide appropriate advanced primary care payment structures aligned with optimal care delivery in primary care settings;
- assure engagement of relevant stakeholders; and
- advance statewide initiatives to achieve better patient health, improved quality and continuity of care while decreasing preventable costs.

(4) Program Delivery Office:

Within OQPS, the Division of Health Care Innovation is responsible for driving collaboration and coordination across multiple agencies. DHCI supports and coordinates SIM-funded programs, and provides policy, governance, and technical oversight for the Statewide Health Information Network for New York.

DHCI works closely with OHIP, DFS, OPH, OPCHSM, private payers, medical associations, workgroup members, and other stakeholders to support the SHIP.

In addition to the day-to-day oversight of SIM and SHIP activities, DHCI leads efforts to align existing state and federal programs to improve the health of New Yorkers. These efforts support the development of a robust health system infrastructure capable of achieving the Triple Aim. These coordination activities support alignment, sustainability, and progress among the many SHIP initiatives.

SECTION II: WORKGROUP RECOMMENDATIONS

Three workgroups were organized in early 2015 to ensure the array of stakeholders across the health care landscape were engaged and committed to achieving SHIP goals. An additional group, the Health Innovation Council, was formed to provide guidance and oversight over each of the topical workgroups and offers policy, legislative, and budgetary guidance. The purpose of each committee and workgroup is described in this section, inclusive of recommendations for legislative action forwarded by the committees.

Health Innovation Council[6]*:* The Innovation Council address' the following charges:

- frame a cohesive policy agenda to advance the Triple Aim;
- provide guidance on key decision points and potential policy recommendations developed by topical workgroups; and
- consider and offer guidance to support the consistency of vision, mission, metrics and incentives across key programs.

Council recommendations: The Health Innovation Council met during 2017. There are currently no recommendations for legislative consideration.

Integrated Care Workgroup[7]**:** The Integrated Care Workgroup was established in 2015 to:

- create a vision for 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 to achieve a higher-performing primary care system to support payment change; and to
- ensure aligned incentives and supports necessary to achieve the Triple Aim.

[6] Materials and presentations from Innovation Council meetings are posted publicly.
[7] Materials and presentations from the Integrated Care Workgroup are posted publicly.

Workgroup recommendations: The Committee issued their final report in December 2016. There will be no further reports on this committee's activity in the Annual Report.

APC Statewide Steering Committee[8]: As a multi-stakeholder group, the Statewide Steering Committee serves as the neutral convener of the New York State APC model. Committee members include health plans, physician groups, practice representatives and hospital systems, as well as academic, consumer and purchaser representatives. The committee is guided by a mutually agreed upon statement of vision, goals, core principles, and project objectives.

The APC Statewide Steering Committee is charged with providing strategic direction and guidance to the State during the implementation and regional roll-out of APC , including:

- advising the NYSDOH on the evolution of the APC model to reflect lessons learned during the implementation process;
- providing guidance about regional, state, and federal alignment across diverse initiatives to ensure efficiency and coordination to achieve common goals; and
- reporting to the Health Innovation Council twice yearly to offer legislative and regulatory recommendations as needed and appropriate.

Accomplishments for the 2017 program year include oversight and support of:

- statewide evaluation of SIM by CMMI;
- developing a process for production of the first APC scorecard;
- overseeing the implementation of expanded practice transformation assistance to accelerate practice enrollment in APC;
- establishing three ROMCs in the Capital District/Hudson Valley, Metro, and Finger lakes regions;
- collaboration with the Adirondack ROMC;
- producing and disseminating the first APC scorecard;
- alignment of APC with the federal Quality Payment Program;
- HIT enabled quality measurement; and

[8] Materials and presentations from Statewide Steering Committee meetings are posted publicly.

- facilitating the transition from APC to the New York State Patient Centered Medical Home 2017 model.

Workgroup recommendations: The APC Statewide Steering Committee does not have any legislative recommendations for inclusion in this report.

Workforce Workgroup[9]: The Workforce Workgroup is charged with promoting a NYS health workforce that supports and assures comprehensive, coordinated, and timely access to care that promotes health and well-being by:

- making recommendations to the Health Innovation Council and the Delivery System Reform Incentive Payment Program Performing Provider Systems Panel regarding workforce needs to support development and promotion of integrated care delivery to result in health improvement;

- developing recommendations and providing guidance to PPS' to support and evolve the health care workforce consistent with PPS goals and objectives;

- providing guidance and recommendations on SIM-funded workforce initiatives including, but not limited, to development of new rural primary care residency programs and demonstrations to retain physicians in the state;

- identifying existing educational and other resources available to educate, train and re-train individuals to promote a workforce that supports and promotes evolving care models including integrated care delivery and primary care as supported in both SIM and DSRIP under SHIP;

- developing recommendations to align the supply of clinical and non-clinical health care workers in key geographies with current and emerging demands consistent with overarching SIM and DSRIP goals and objectives;

- developing recommendations regarding education and training needs to ensure capacity to support integrated care delivery systems including, but not limited to, care coordinators, case managers and other roles necessary to promote integration and access to care across the continuum;

- examining data and analytic resources currently available to assess current and future workforce needs, identify gaps, and make recommendations; and

- coordinating efforts with the Council on Graduate Medical Education regarding issues related to Graduate Medical Education and with the Rural Health Council regarding rural health issues.

[9] Materials and presentations from the Workforce Workgroup are available publicly.

The Workforce Workgroup uses five subcommittees to address these areas. Sub-committee activities, updates, and legislative recommendations from each subcommittee is described below.

SUBCOMMITTEE	COMMITTEE CHARGE	LEGISLATIVE RECOMMENDATIONS
Subcommittee #1: Barriers to Effective Care Coordination	This subcommittee identifies core competencies and care coordination functions carried out by licensed and non-licensed workers as well as non-licensed family and friends; identifies barriers that, if addressed, would support the achievement of DSRIP and SIM goals under SHIP and advance the progress of these transformative activities; and identifies ways to address such barriers.	None
Subcommittee #2: Care Coordination Curriculum	Identifies core care coordination competencies that can be recommended for inclusion in the educational curricula for licensed professionals.	None
Subcommittee #3: Care Coordination Training Guidelines	Identifies recommended core curriculum for training workers in care coordination titles.	None
Subcommittee #4: Health Care Workforce Data	Identifies and addresses gaps in health care workforce data. Currently, DOH collects data on a small number of professions through voluntary surveys administered as part of professional license renewal, but rates of responses vary, and information is not sought from all health care practitioners.	(1) Collect additional information as part of the existing, publicly available Physician Profile. This information would be used to improve tracking of workforce trends and would help inform policy decision. Consistent with that recommendation, NYSDOH proposed legislation to incorporate additional information into the Physician Profile.
Subcommittee #5: Primary Care and Behavioral Health Integration	Identifies barriers to integration of physical and behavioral health services related to scope of practice, regulatory, or reimbursement limitations.	None

HIT, Evaluation, and Transparency Workgroup[10]: The HIT, Evaluation and Transparency Workgroup was formed in 2014 and continued to meet quarterly throughout 2017. The workgroup mandate is to:

- evaluate NYS health information technology infrastructure and systems as well as other related plans and projects including but not limited to the All Payer Database, Statewide Health Information Network of New York, and the State Planning and Research Cooperative System;

- develop recommendations for NYS to move towards a comprehensive health claims and clinical database to improve quality of care, 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 SHIP's impact on system transformation and Triple Aim goals and objectives;

- produce APC scorecard to support the Triple Aim; and

- design and implement/manage a plan that will shape new IT efforts to best support other initiatives and incentivizes adoption of these efforts.

Accomplishments for the 2017 program year include oversight and support of:

- the APC Scorecard;

- HIT enabled quality measures and new approaches to increase capabilities supporting care coordination;

- continuing progress and development of the SHIN-NY and APD;

- consumer tools and transparency initiatives;

- technical alignment with SPARCS;

- HITRUST, security integration, cybersecurity, and incident response;

- Qualified Entity and PPS integration; and

- the Practice Transformation tracking system.

[10] Materials and presentations from the Health Innovation Technology, Evaluation, and Transparency Workgroup are available publicly.

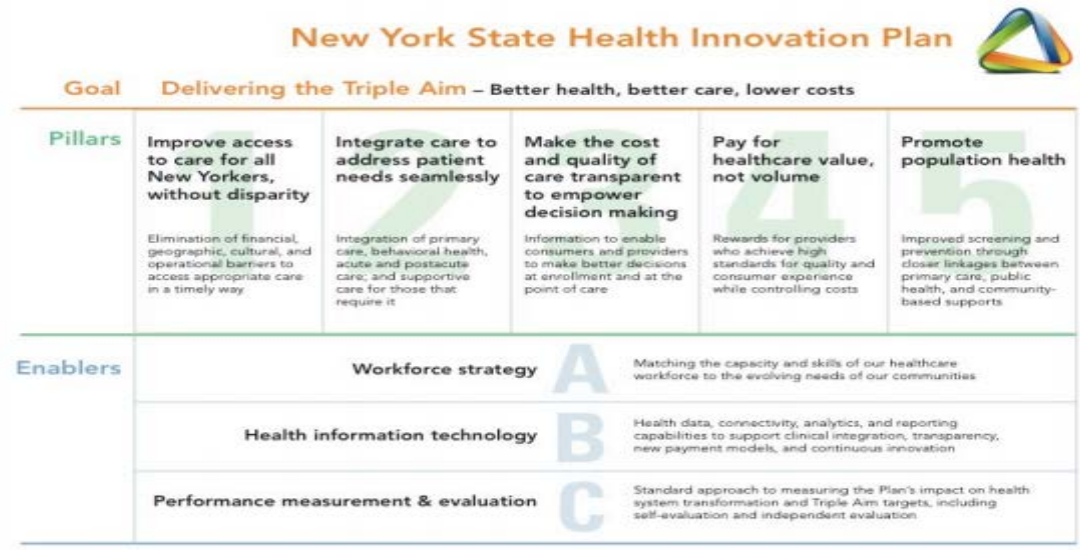
SECTION III: YEARLY PROGRESS TOWARDS NEW YORK STATE HEALTH INNOVATION PLAN GOALS

This section of the Annual Report describes progress made towards the SHIP goals in 2017. Progress is reported by pillar and enabler and incorporates reports from the variety of stakeholders charged with implementing the SHIP. An overview of the key initiatives associated with each pillar and enabler is provided.

Mechanisms for Achieving SHIP Goals

The SHIP is comprised of five "strategic pillars" and three cross-cutting "enablers", which collectively transform New York's health care system from a reactive, volume-based care-delivery system to a proactive, prevention-focused, value-oriented system that is both patient-centered and broadly accessible. The SIM has adopted similar "drivers" in support of the SHIP and achieve SIM specific goals over the grant period. Figure 1 provides the broad overview of the pillars and enablers for the SHIP which have neem integrated into the SIM.

FIGURE 1: STRATEGIC PILLARS & ENABLERS



SHIP Initiative by Departmental Owner Under the SHIP, each strategic pillar and related initiative was assigned clear departmental ownership.[11] The table below lists each SHIP initiative by pillar, enabler, and departmental owner. The table also indicates whether the initiative is supported through SIM grant funding.

[11] New York State Health Innovation Plan, page 150

TABLE 1: SHIP PILLARS AND ENABLERS BY DEPARTMENTAL OWNER

	Pillar	Owner	SIM Funded
	Ensure Timely Access to Care		
1.1	Leverage consumer insights to increase adoption of health insurance coverage.	NYSoH	No
1.2	Strengthen our safety-net providers that serve New York's most vulnerable populations, regardless of ability to pay.	OHIP	No
1.3	Increase workforce capacity in underserved regions of New York State.	OPCHSM/OQPS	Yes
1.4	Make care more accessible through extended hours, open access scheduling, and use of technology.	OQPS	Yes
	Integrated Care for All		
2.1	Establish Advanced Primary Care (APC) as a universal model for statewide, multi-payer adoption.	OQPS	Yes
2.2	Promote consistent standards and expectations for APC capability on a spectrum of advancement to achieve fully integrated care.	OQPS	Yes
2.3	Adopt a regional approach to system transformation including practice transformation support, leveraging reliable and tested technical assistance approaches.	OQPS	Yes
2.4	Deploy an APC recognition process that builds on NCQA standards or equivalent standards such as CPCi criteria.	OQPS	Yes
2.5	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.	OHIP/OQPS	Yes*[12]
2.6	Encourage the development of integrated service and payment models including but not limited to Accountable Care Organizations.	OQPS	Yes
	Increase Transparency to Empower Consumers, Payers and Providers		

[12] * indicates partial funding through SIM. Funds from other Departments, Offices and initiatives may be used.

3.1	Deploy a New York State consumer transparency portal.	OQPS	No
3.2	Create a patient portal.	OQPS	No
3.3	Increase data availability to enable third-party innovation in transparency tools.	OQPS	Yes*
3.4	Increase adoption of Value-Based Insurance Design (VBID).	OQPS/DFS	Yes
3.5	Continue to amplify best practices in self-management of chronic disease.	OQPS	Yes
	Pay for Value not Volume		
4.1	Embrace value-based payment across primary care and specialty care for hospitals and other providers.	OQPS	Yes
4.2	Establish a flexible framework for value-based payment for APC.	OQPS/OHIP	Yes
4.3	Adopt value-based payment for APC within both Medicaid and State and Public Employees.	OQPS/OHIP/DCS	Yes*
4.4	Encourage Medicare to make value-based payment for APC more universally accessible to providers.	OQPS/OHIP	Yes
4.5	Align regulatory processes with adoption of value-based payment.	DFS	No
	Promote Population Health - Connect Primary Care to Population Health Improvement		
5.1	Strengthen local health planning and increase the involvement of primary care providers.	OPH	Yes
5.2	Develop population health reports and draw on Prevention Agenda community health plans, routinely integrating them with performance improvement efforts undertaken by APC practices.	OPH/OQPS	Yes*
5.3	Build and maintain community resource registries and ensure that APC practices have easy access to them.	OPH	No
5.4	Create a formal communication channel between the primary care community, local health planning stakeholders, and local Prevention Agenda partnerships.	OPCHSM	No
5.5	Ensure that care coordinators are experts in fostering community linkages.	OPH/OQPS	Yes*

	Enabler	Owner	SIM Funded
	Workforce		
A.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.	OQPS/OPCHSM	Yes
A.2	Update standards and educational programs to reflect the needs of delivering the APC model, particularly trainings around care coordination, quality and performance improvement techniques, multidisciplinary teamwork, and necessary administrative and business skills.	OQPS/OPCHSM/OHIP	Yes
A.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.	OQPS	Yes
A.4	Develop more robust working data, analytics, and planning capacity throughout NYS.	OQPS	Yes
	Health Information Technology		
B.1	Encourage the adoption of certified EHRs.	OQPS	Yes*
B.2	Promote provider participation in bidirectional health information exchange 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.	OQPS	Yes*

B.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.	OQPS	Yes*
B.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.	OQPS	Yes*
B.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.	OQPS	No
B.6	Make government datasets (cleansed of personally identifiable information) publicly available to encourage transparency and innovation in research and discovery.	health.data.ny	No
B.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.	OQPS	Yes
	Performance Measurement and Evaluation		
C.1	Advanced Primary Care Scorecard.	OQPS	Yes

Access to Care

Timely, appropriate access is the cornerstone of quality health care and foundational to achieving the SHIP goals. New York has a proud history of providing access to care, with one of the lowest proportions of uninsured populations across the country.

The SHIP builds on this history to ensure access without disparity, inclusive of all populations across NYS of any means, circumstance, background, or geography. The SHIPs ambition is to improve access and continue to be a leader in providing timely access to health care for all. The approach is comprised of four parts:

- leveraging consumer insights to increase adoption of health insurance coverage;
- strengthening safety-net providers that serve New York's most vulnerable populations, regardless of ability to pay;
- increasing workforce capacity in underserved regions of New York State; and
- making care more accessible through extended hours, open access scheduling; and use of technology.

ACCESS TO CARE: NEW YORK STATE OF HEALTH MARKETPLACE (NYSoH)	
PILLAR 1.1	Leverage consumer insights to increase adoption of health insurance coverage

NYSoH went live on October 1st, 2013. NYSoH is an organized marketplace designed to help people shop for and enroll in health insurance coverage. Individuals, families and small businesses can use the Marketplace to help them compare insurance options, calculate costs and select coverage. The Marketplace uses a single application that helps people to check their eligibility for health care programs - Medicaid, Child Health Plus, Qualified Health Plans, and the Essential Plan - and enroll in these programs if they are eligible. The Marketplace also provides information about financial assistance available to New Yorkers to help them afford health insurance purchased through the Marketplace. The SHIP established a goal that the Marketplace would help more than 1 million individuals get health insurance over three years, including New Yorkers who had previously been uninsured. Achieving this goal would represent an almost 15% reduction in the uninsured population, once additions to Medicaid, CHIP, and other private payers are included.

In 2017 enrollment through NYSoH reached its highest point reported to date. On December 20, 2017 enrollment through NYSoH reached over 4.1 million at close of business on December 15 – the deadline for January 1, 2018 coverage – exceeding enrollment from the previous year by 700,000. New York has seen a significant, corresponding reduction in the number of uninsured, from 10% in 2013 when the Marketplace opened to under 5% in 2017. This represents a 50% reduction in the number of uninsured New Yorkers since the Marketplace opened.

More information about NYSoH is available on their website.

ACCESS TO CARE: DSRIP	
PILLAR 1.2	Strengthen our safety-net providers that serve New York's most vulnerable populations, regardless of ability to pay.

Since 1997, NYSDOH has partnered with the Centers for Medicare & Medicaid Services to deliver innovative models of care for its Medicaid members through a 1115 waiver. More than 5 million, or 80% of New York's Medicaid members participate in the managed care program and other programs authorized through the State's 1115 Medicaid Redesign Team waiver. In April 2014, CMS recognized the successes of the Medicaid Redesign Team by approving an amendment to the 1115 waiver, reinvesting $8B to support a DSRIP program aimed at promoting community-level partnerships to reduce avoidable hospital use by 25%.

DSRIP has shown remarkable success in its aim to build community-level networks focused on earning performance payments by improving location-specific population health goals and promoting community-based care, resulting in better quality and better outcomes for Medicaid members. The DSRIP program is currently on a trajectory to exceed its goal to reduce avoidable hospital use by 25% by 2020, while its Performing Provider Systems have successfully implemented 95% of their Year 2 project requirements and earned 95% of the available funds through Demonstration Year 2.

Safety-net providers serving New York's most vulnerable populations are strengthened through the inclusion of social determinants of health and community-based organizations in the New York State Roadmap for Medicaid Payment Reform.[13] The Roadmap specifically recognizes that addressing the social determinants of health is a critical element in successfully meeting the goals of DSRIP and value-based payment. New York is fully committed to exploring ways to capture savings accrued in other areas of public spending when social determinants are addressed (e.g. reduced recidivism rates).

To stimulate VBP contractors to venture into this crucial domain, VBP contractors in Level 2 or Level 3 agreements are required, as a statewide standard, to implement at least one social determinant of health intervention. Medicaid Managed Care Organizations contracting with VBP Level 2 providers/provider networks share in the costs and responsibilities associated with the investment, development, and implementation of the intervention(s). Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk. Providers/provider networks/Medicaid Managed Care Organizations may also contract with community-based organizations to satisfy this recommendation. Contracted community-based organizations should expect the inclusion of a value-based component in the contract, such as pay for performance, and be held to performance measure standards. More information about DSRIP is available on their website.

[13] The full New York State Roadmap for Medicaid Payment Reform is available here.

ACCESS TO CARE: PROJECT ECHO®	
PILLAR 1.3	Increase workforce capacity in underserved regions across New York.
ENABLER A.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.
ENABLER A.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.

Project ECHO® increases access to advanced primary care by helping providers improve their abilities to treat complex, chronic, medical conditions. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub. Providers in rural areas receive training in diagnosing and treating complex conditions such as: hepatitis C, HIV, tuberculosis, chronic pain, endocrinology, behavioral health disorders, and many others. This in turn improves the health care available to populations living in underserved areas.

In 2016, building on the proven Project ECHO® model, the SIM team developed and released a Request for Proposals to identify and fund up to four hub sites in New York. Four hub sites were identified, and preliminary contracts developed. However, full implementation of the Project ECHO® portion of the SIM plan was delayed by issues finalizing the project contracts and work plans with the hub sites.

In the 2017 project year the following activities were completed:

- releasing the Project ECHO® RFP to fund up to four new hub sites;
- selecting sites to be funded and executing the contracts; and
- curriculum development and hub site recruitment by contractors.

More information about regional Project ECHO® activities is provided in Table 2 below. The table lists the contractors, health focus areas, and coverage areas for the project. All contracts listed below were awarded following a competitive procurement process. The activities conducted by each contractor expand the supply of clinically-trained workers in key geographies by working with providers and educators to provide specialty training programs; sharpen recruitment and retention policies and incorporate telehealth technology to expand the geographical reach of the existing primary care workforce.

TABLE 2: Project ECHO® Sites

Contractor Name	Health Focus Area	NYS Counties
SUNY Upstate Medical University	Diabetes prevention, evaluation, treatment and management	Broome; Cayuga; Chemung; Chenango; Cortland; Herkimer; Jefferson; Lewis; Madison; Oneida; Onondaga; Oswego; Otsego; Seneca; St. Lawrence; Tioga; Tompkins
Westchester Medical Center Health Network	Psychiatric medication decision-making for primary care	Westchester; Delaware; Dutchess; Orange; Putnam; Rockland; Sullivan; Ulster
Montefiore Medical Center	Alzheimer's and dementia; opioid use and pain management; cardiology and coronary heart failure; hepatitis C and children's mental health, ADHD and behavioral health	Bronx
Champlain Valley Physicians Hospital	HIV and hepatitis C	Clinton; Essex; Franklin; St. Lawrence

ACCESS TO CARE: RURAL RESIDENCY PROGRAM	
ENABLER A.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.
ENABLER A.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.

The Rural Residency Program is a targeted workforce strategy to address primary care shortages in rural areas. The mechanism for addressing primary care shortages is to use rural residency and physician retention strategies. The program supports the development of accredited innovative, rural-based GME programs that will help alleviate regional and primary care workforce shortages and prepare physicians to deliver quality services in a networked, team-based, value-driven, primary care focused model. The funded GME programs create new opportunities for medical school graduates to train in under-served rural areas of NYS and foster community and provider collaborations to develop strategies to help ensure that the new physicians continue to practice in rural NYS communities. Successful implementation and replication of the programs will result in increased access to health care services for New Yorkers who are geographically, economically or medically vulnerable.

In 2016, a competitive RFA was issued. Applicants were required to propose the development of new GME programs in one of the following three areas:

- developing new GME programs in rural areas;
- restructuring or expanding existing accredited GME programs to include a substantial number of new rural training positions in a newly identified rural geographic area; or
- developing a separately accredited new Rural Training Track Program via a partnership between an urban hospital and either a rural hospital(s) or a rural non-hospital clinical training site(s).

Applicants were also required to submit proposals to develop primary care programs in internal medicine, family medicine, or pediatrics.

In 2017, five contracts were competitively procured providing coverage to 19 New York State counties. To successfully implement the contracts, recipients completed or were in the process of completing, the following activities for the 2017 program year:

- submit completed assessment for feasibility of implementing rural GME program;

- identify sponsoring institutions and their financial responsibilities;
- complete sustainability plans;
- develop faculty and resident recruitment plans;
- propose program models with diverse clinical rotation sites;
- develop and update curriculum to include didactic topic schedules, clinical rotation schedules, simulation sessions, and evaluation feedback systems;
- document affiliation agreements with ambulatory care and hospital inpatient sites;
- provide evidence of collaboration with community partners who are involved with APC practice transformation activities;
- provide evidence of progress towards completing Accreditation Council for Graduate Medical Education or American Osteopathic Association applications; and
- provide evidence of effort to participate in the National Residency Matching Program.

Program contractors and coverage areas are described in Table 3, below. The activities conducted by each contractor expand the supply of clinically-trained workers in key geographies by working with providers and educators to change admissions, education, and training programs, and sharpen recruitment and retention to expand the geographical reach of the primary care workforce.

TABLE 3: Rural Residency Contracts

Contractor Name	NYS Counties Covered
Arnot Ogden Medical Center	Steuben
Mary Imogene Bassett Hospital	Chenango; Delaware; Herkimer; Otsego; Schoharie
Cayuga Medical Center	Cortland; Tioga; Chemung; Schuyler; Seneca; Cayuga
Champlain Valley Physicians Hospital	Clinton; Essex; Franklin; St. Lawrence
Samaritan Medical Center	Jefferson; Lewis; St. Lawrence

ACCESS TO CARE: APC ACCESS TO CARE COMPETENCIES	
PILLAR 1.4	Make care more accessible through extended hours, open access scheduling, and use of technology.

APC (described under Pillar 2.1) was developed to include concrete standards and expectations for progress through practice transformation. APC makes care more accessible by requiring that enrolled practices offer open access scheduling and use technology to improve patient access to care. Under APC practices are required to demonstrate completion or mastery of the following areas:

- an on-call schedule that ensures timely telephonic, page and/or secure communication methods (e.g. portal) with a qualified provider that is accessible 24/7, either through a nurse call line or on-call provider;
- improved communication capabilities evidenced through secure communication methods (e.g. portal) or nurse call line for other non-urgent care;
- assured patient navigation to other care coordination and referrals to educational resources (e.g. diabetic education tools, navigation to patient health questionnaires, proper utilization of ED vs office visits); and
- satisfy at least 80% of practice demand for same-day scheduling.

In 2017, 558 primary care practices enrolled in APC and received support to improve access to care for New Yorkers.

Integrated Care for All

The SHIP aims to increase the number of people receiving integrated care. Under SHIP, all New Yorkers should have access to a new care model, APC, which builds on the principles embodied by the NCQA-certified medical home. The ultimate goal of the Integrated Care Pillar is that that 80% of the population receives health care services through an integrated care-delivery model, such as APC, by 2020.

The health care system has historically been 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. Under SHIP, care will be integrated around patients' needs. Patient, provider and payer engagement is key to the long-term success of the plan.

The broad strategy for promoting integrated care is organized in six parts:

- establish APC as a universal approach for statewide, multi-payer adoption;
- promote consistent standards and expectations to achieve fully integrated care within APC;
- adopt a regional approach to health care transformation including individualized practice transformation support, leveraging reliable and tested technical assistance approaches;
- deploy a recognition process that builds on NCQA or equivalent standards;
- 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; and
- encourage the development of integrated service and payment models including but not limited to Accountable Care Organizations.

INTEGRATED CARE FOR ALL: DEVELOP ADVANCED PRIMARY CARE MODEL	
PILLAR 2.1	Establish APC as a universal model for statewide multi-payer adoption.

In 2015 the Integrated Care Workgroup convened and met monthly under the charge to: (1) establish eligibility criteria, metrics, and milestones for APC; (2) align Medicaid DSRIP projects, PCMH programs, ACO development, SIM initiatives, (3) define and develop primary care practice transformation support, and (4) define value-based payment options and recommend payment models to be adopted across payers in support of APC.

In December 2016, the Workgroup issued a final report, noting key accomplishments that supported the final development of the APC model, including the following milestones:

- **Established APC Care Model Capabilities:** Built on existing multi-payer advanced primary care/medical home initiatives in New York and throughout the country, along with a growing evidence base, the Integrated Care Work Group provided the input to the development of the design of the APC model. Design elements include detailed specifications, standards and milestones for assessing a primary care practice's achievement; a common set of measures to be used to evaluate the practice's impact on improving quality and population health; and methodologies to reduce avoidable utilization and costs.

- **Established a Practice Transformation Model:** Through its deliberations, the Workgroup developed parameters for practice transformation to support APC. The NYSDOH developed and issued a RFA to vendors of practice transformation technical assistance to help practices achieve APC capabilities.

- **Initiated discussion for Value-Based Payment for APC:** Substantial progress has been made in generating support from commercial payers in New York. The scope includes multi-payer supported primary care reform coupled with value-based payments. Together, both are critical to achieving and sustaining advanced services necessary for achieving the triple aim, and which are not otherwise adequately supported by traditional fee-for-service models.

The APC Statewide Steering Committee continues the work of ICWG, providing oversight and support for New York's APC model.

INTEGRATED CARE FOR ALL: APC CAPABILITIES, GATES, AND MILESTONES	
PILLAR 2.2	Promote consistent standards and expectations for APC capability on a spectrum of advancement to achieve fully integrated care.
APC (described in Pillar 2.1) was developed to include concrete standards and expectations for progress through practice transformation. The APC model is described in detail on p. 7-15 of the Integrated Care Workgroup Final Report, available here. The adoption of a uniform model of practice transformation supported through SIM funding promotes consistent standards and expectations for advanced primary care capability as practices work to achieve fully integrated care.	

INTEGRATED CARE FOR ALL; PRACTICE TRANSFORMATION TECHNICAL ASSISTANCE CONTRACTS	
PILLAR 2.3	Adopt a regional approach to system transformation including practice transformation support, leveraging reliable and tested technical assistance approaches.
ENABLER A.2	Update standards and educational programs to reflect the needs of delivering the APC model, particularly trainings around care coordination, quality and performance improvement techniques, multidisciplinary teamwork, and necessary administrative and business skills.

In 2016, two competitive RFAs were issued seeking applications for responsive and qualified contractors to provide regional Practice Transformation Technical Assistance to support primary care practices to complete APC. PT TA contractors funded through SIM function as part of a larger team that is inclusive of practices, payers, HRI, NYSDOH, and other SHIP stakeholders. Contractors assist practices and providers to develop the systems and processes necessary to meet the goals of the Triple Aim: improving patients' experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of care through achievement of APC-specific competencies. More specifically, funded contractors provide the following services to primary care practices in designated regions throughout the State:

- an initial assessment of practices' readiness to receive PT TA services as defined by APC milestones and gates (described below) using a tool to be developed by HRI/NYSDOH and shared with funded contractors;
- support to practices in building capabilities to reach APC goals and to progress through three gates for up to two years, depending on the initial readiness of the practice; and
- submission of reports on practice achievement of APC gates and milestones to HRI/NYSDOH.

PT TA contracts were awarded regionally. A total of 26 contracts were awarded as of 2/1/2017. Contracts supported the rollout of the APC model in February 2017.

Information about PT TA entities is available here.

INTEGRATED CARE FOR ALL: INDEPENDENT VALIDATION AGENT & TRACKING PROGRESS	
PILLAR 2.4	Deploy an APC recognition process that builds on NCQA standards, or equivalent standards such as CPCi criteria.
ENABLER B.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.

OQPS proposed to contract with an independent validation agent to ensure compliance and accountability among the contracted PT TAs and primary care practices enrolled in APC. The role of the independent evaluation agent would be primarily to ensure compliance with APC goals, prevent duplication of PT TA services, and provide recommendations to the NYSDOH for adoption by PT TAs.

One key activity proposed for the independent validation agent was the review of material evidence submitted by PT TAs on behalf of practices enrolled in APC to ensure accountability. A RFA for an independent validation agent entity was issued in 2016 and four applications were returned. Further action in this area was postponed in 2016 due to ongoing discussions with SHIP governance bodies.

In 2017, a system to track and audit material evidence submitted by PT TAs on behalf of practices enrolled in APC was developed. The system, the Practice Transformation Tracking System, supports the APC recognition process which builds on NCQA standards. Through PTTS, primary care practices engaged in APC will receive recognition for progressing through the model and transforming their practice.

Following discussions with stakeholders and the Statewide Steering Committee about the sustainability of APC after SIM funding has ended, NYSDOH entered discussions with NCQA to align APC with their 2017 PCMH model. With the advice and consent of CMMI, the NYS SIM team has adapted the APC program to reduce burdens on providers by updating the model to align with these national NCQA standards. Due to this change, and the pending contract with NCQA, validation activities originally proposed will be completed by NCQA upon finalization of the contract. Activities NCQA will oversee and complete will include: (1) conducting practice transformation compliance audits; (2) conducting triggered audits of practice transformation activities; (3) proposing corrective action plans to remedy deficiencies in practice transformation activities; (4) providing monthly reports on audit findings and progress to NYSDOH; and (5) proposing recommendations to NYSDOH for adoption by practice transformation agents.

INTEGRATED CARE FOR ALL: DEVELOPING NEW SPECIALTY MODELS	
PILLAR 2.5	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.

In 2017, OQPS, OHIP, and other stakeholders from NYSDOH collaborated to reply to a Request for Information from the Centers for Medicare & Medicaid Services. The RFI sought innovative ideas from states, such as NY, to accelerate the adoption of value-based payment. In response, NYSDOH recommended two specialty models (described below) to continue to support and assure integration with complementary care delivery models for special or high needs populations.

State-led physician specialty models: A broad class of state-led physician specialty models that engage specialty physicians in alternative payment models, such as the proposed state-led alternative payment model. The model would be a multi-payer physician specialty model that extends the APC model to high cost, fee-for-service specialty care. Specialty models such as these are important because specialty care comprises 40-60% of all medical spending in New York. The specialty care for chronic disease is even higher for the Medicaid population.

One potential approach is an arrangement that builds on existing value-based payment infrastructure supporting APC and uses global payments to improve specialty care quality and integration with primary care. We envision a specialist value-based payment model with multi-payer contracts developed around discrete, data-driven utilization status efficiency and quality measures which encourage high-value care and reduce costs associated with complex chronic care. Such models would provide transparency to patients and primary care providers about current referral patterns and opportunities for high value referrals to specialists which could be organized by patient preference or aggregated specialist efficiency scoring.

Based on lessons learned from developing the primary care model, this model would be rolled out regionally and include voluntary participation from commercial payers through ROMCs. The model would be scalable to the breadth of NYS. Much like with the proposed state-led APM model administrative burdens on practitioners are reduced as existing infrastructure is used and expanded. New York's HIT infrastructure is particularly important for the proposed mode because the APD will support the design of outcome-based quality measures which will provide a basis for payment.

State-led model integrating specialty and primary care physicians and hospitals: A state-led model that integrates specialty care, primary care, and hospital settings. NYSDOH encouraged CMMI to support and test such models because they recognize that the determinants of care quality surpass the ability of any one provider in any one setting to provide.

The model design would be like the state-led specialty model described above, an all-payer, global payment arrangement that builds on success from the APC model to engage diverse stakeholders in the design and appropriate implementation of the model. One of the key features of this model is that it would govern care delivered across care settings by assigning responsibility for patients receiving care in diverse settings to a "care lead." The provider designated a "care lead" would be accountable to reconcile and coordinate their patient's care, informed by timely and relevant data provided from all providers involved in a patient's care. These proposals are currently under review by CMMI.

INTEGRATED CARE FOR ALL: ROMC	
Pillar 2.6	Encourage the development of integrated service and payment models including but not limited to Accountable Care Organizations.

ROMCs are regional consensus development entities supported by OQPS through SIM funds. They are a primary mechanism to ensure that multi-payer model development across the State is informed by regional stakeholders and tailored to the appropriate regional context. ROMCs organize themselves and the structure of their work in a manner consistent with local health care markets or existing models, payer mix and primary care reimbursement actualities, regional populations, patients/purchasers and other consumers, needs, concurrent initiatives and resources that are all unique to a region. The Adirondack regional model served as an exemplar of a mature ROMC model which informed the development of the statewide ROMC initiative.

The SIM team extended invitations to payers and stakeholders in regions across NYS to participate in ROMC activities. ROMCs were developed in three regions across NYS: Capital District/Hudson Valley, New York Metropolitan areas, and the Finger Lakes. Each ROMC established regional charters and scheduled a series of on-going meetings to develop regional payment frameworks that operationalize APC.

SIM funding supported professional facilitation and convening services for each ROMC to support the design of these regional payment frameworks. Supporting the ROMC's to develop regional payment frameworks to operationalize APC and providing professional facilitation and convening services to ROMC's are important on-going efforts to increase the share of insurers reimbursing under VBP models to 80%. Efforts to organize ROMCs in the remaining NYS regions will continue in 2018.

INCREASE TRANSPARENCY TO EMPOWER CONSUMERS, PAYERS, AND PROVIDERS

Under the SHIP consumers, providers, and payers will experience unprecedented levels of health data transparency. Health data transparency empowers consumers, providers, and payers, to make increasingly informed decisions about the quality and costs of the care they seek and provide. The SHIP proposed to create and improve statewide transparency of core quality, utilization and cost metrics at a facility and practice level. The SHIP also included plans for a consumer-targeted website to provide this information in a user-friendly format to enable consumer action and shared decision-making.

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 health care 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.

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. The SHIP targets 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:

- deploy a New York State consumer transparency portal;
- create a patient portal;
- increase data availability to enable third-party innovation in transparency tools;
- increase adoption of value-based insurance design; and
- continue to amplify best practices in self-management of chronic disease.

INCREASE TRANSPARENCY TO EMPOWER CONSUMERS, PAYERS, AND PROVIDERS: CONSUMER TRANSPARENCY PORTAL	
PILLAR 3.1	Deploy a New York State consumer transparency portal.
ENABLER B.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.

NYSDOH implemented the Quality Assurance Reporting Requirements in 1994 and made the data available in a consumer tool in 1995.[7] In 2014, NYSDOH redesigned its Health Profiles[8] site. Health Profiles enables consumers to find and compare quality and safety data on New York's hospitals, nursing home, home care, and hospice facilities. Since 2015, NYSDOH has actively engaged in research on consumer transparency, conducting focus groups and research assessing available consumer information.[9] NYSDOH has worked with the New York Academy of Medicine to identify approximately 33 shoppable health care goods and services, including: (1) services traditionally seen as "shoppable" by health care payers and policy makers; (2) services of notable interest to health care consumers, as reflected in consumer-focused research; and (3) services that align with New York State's broader health agenda. The research formed the basis for further research and focus groups.

In 2017, New York launched a Provider & Plan Look-up tool[10] that supports consumers looking for providers and enables Health Exchange customers to know which providers are in which health plan networks. Improvements made to the Health Profiles 'comparison tool' allows consumers to more easily examine quality, procedure volume, and look up facility citations. In 2017, Health Profiles saw 291,020 unique users, an 18% increase over 2016. On average, 3,600 visitors visit the site weekly. The All Payer Database started development on a public website that will display visualizations through Tableau.

Work continued with the New York Academy of Medicine to carry out interviews with 30 New York State health care consumers who had used one or more of the 'shoppable' health care services identified and described in a previous research. A preliminary report entitled, *Experience and Preference Choosing Providers for Select Services and Procedures: Interviews with New York Consumers; Transparency Preliminary Report,* was delivered to NYSDOH in December 2017.

NYSDOH also engaged with another vendor, Honest Health, to begin to develop a prototype for a consumer website with a price and quality focus. The website concept was presented at the December 14, 2017 HIT, Evaluation, and Transparency Workgroup meeting with the goal of gaining feedback on possibilities for engaging consumers.[11]

[7] eQARR is an interactive online tool that allows consumers to view quality performance results for health plans in New York State.
[8] Health Profiles makes it easy to find quality and safety information.
[9] Final reports for consumer research and focus groups can be found here.
[10] NYS Provider & Health Plan Look-up helps consumers know which providers participate in their network.
[11] See https://www.health.ny.gov/technology/innovation_plan_initiative/docs/2017-12-14_hit_wrkgrp_slides.pdf.

INCREASE TRANSPARENCY TO EMPOWER CONSUMERS, PAYERS, AND PROVIDERS	
PILLAR 3.2	Create a patient portal.
ENABLER B.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.

In collaboration with the United States Department of Health and Human Services and the New York eHealth Collaborative, NYSDOH began efforts to develop a statewide patient portal through which patients could access their personal health information. A design challenge, hosted by NYeC, was held in 2013 to identify possible prototypes. Entries were evaluated by health care providers, hospital leadership, public advocates, entrepreneurs, public officials, IT experts, and industry leaders. The engaged audience encompassed a broad spectrum—patient advocates, technology specialists, representatives from RHIOs, small practice doctors, media, and members of the general public. Entries were evaluated based on patient's abilities to:

- easily access their health care records whenever they want them. For example, to find out when they started taking a particular medication, when they had their last tetanus shot, or to view recent lab results;
- share their records with providers—such as to get a second opinion on a diagnosis or share data from a specialist with their family doctor;
- select and control who is allowed to have access to their medical history; and
- be more empowered in their health care management and better able to partner with doctors in their care.

Following a RFP, a contract was awarded to support initial portal development. The initial portal developed built on the existing SHIN-NY infrastructure to connect patients to their available data and supported: categorization of health information, downloads of clinical data, uploads of important documents not currently available electronically, storage for notes about health data, a patient inbox for Direct / secure messaging between patients and their provider, visual customization as needed including entity-based versions, certification for Meaningful Use Stage 2, and integration of data from New York City and New York State Immunization Registries.

NYSDOH subsequently completed landscape, marketplace, and feasibility analyses to assess the utility of the planned patient portal. Through these efforts it was determined that functionalities planned for the portal were not viable. There remains a need for consumer access, but the portal developed was not the right tool to meet that need given broader market trends in consumer tool development. NYSDOH is focused on making data available through tools such as these in a secure manner. Therefore, NYSDOH has closed this project and is redirecting focus to data interoperability and standardization that will support consumer tools using EHR such that consumers can access their data on a variety of platforms and devices.

INCREASE TRANSPARENCY TO EMPOWER CONSUMERS, PAYERS, AND PROVIDERS: APD	
PILLAR 3.3	Increase data availability to enable third-party innovation in transparency tools.
ENABLER B.3	Implement an all-payer database to better assess health and health care across New York and inform planning, program/policy development, and evaluation through analytics and visualization tools.
ENABLER A.4	Develop more robust working data, analytics, and planning capacity throughout New York.

States started developing all-payer claims databases in 1996. Since that time, the databases have demonstrated their value for enabling data-driven health care transformation. In 2011, New York enacted legislation to allow for the creation of the New York APD. The APD will expand the ability of NYSDOH to collect claims and encounter data to the more than 13 million New Yorkers enrolled in different types of health care insurance plans (including the Qualified Health Plan, Essential Plan, Medicare and approximately 9 million Commercial insurance enrollees). The APD will also house Medicaid claim and encounter data.

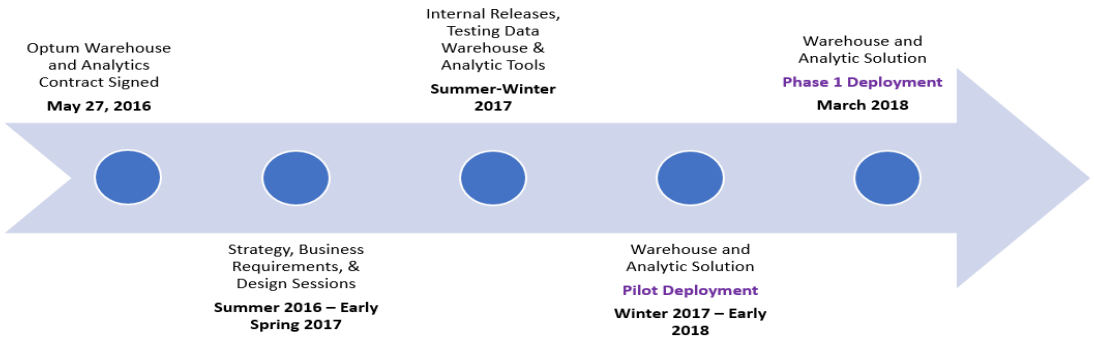
The APD will improve the NYSDOH's master data management and analytic tools available to support effective use of the data. Through a master patient index, master provider index, and a suite of data enrichment tools, the APD warehouse and analytic solution will be able to integrate previously siloed data sources and fill gaps in the types of information available to support DOH's mission. Using best in class analytic tools, including Tableau, SAS, Arc GIS, the APD program offers users easy to use tools and resources. An overview of the APD components is provided in Figure 8, below.

FIGURE 8: ALL PAYER DATABASE OVERVIEW

The APD will directly support health care system reform, transformation, and DFS rate setting activities. The APD will improve NYSDOH's capability to measure the quality of health plans, facilities, programs, and costs.

The timeline for various phases of the APD is described in Figure 9 below

FIGURE 9: ALL PAYER DATABASE DEVELOPMENT TIMELINE



Starting in 2014, planning and implementation activities focused on developing an encounter intake system. The first build was for Qualified Health Plans. The second build in late 2015 expanded collection to include data from Medicaid managed care plans. In 2016, NYSDOH secured a warehousing and analytics vendor, issued proposed regulations, and started the implementation of the APD.

Throughout 2017, NYSDOH worked with their vendor (Optum) to establish appropriate technical connections, satisfy New York State technology security requirements, develop data model designs, create visualizations, stand-up an APD analytic portal, and develop a public web site. Data model subject areas focused on members, providers and facilities, issuers and plans, claims and encounters, and the required reference data. The following data sources/lines of business were integrated within the APD: Medicaid managed care/fee-for-service, Child Health Plus, Qualified Health Plan, and Essential Plan. Data were also integrated from the provider network data system, the health facilities information system, the hospital discharge data system, and vital statistics mortality data. Work also focused on development of a master patient and provider index.

Over 300 individuals from approximately 100 different organizations and state entities attended the annual APD stakeholder forum on April 26, 2017 at the Empire State Plaza. On August 3, 2017, the APD regulations were approved by the State's Public Health and Health Planning Council, were published in the State Register, and became effective on September 13, 2017. The first version of the APD Guidance Manual was publicly released and contained detailed information on program operations, data governance and data submission specifications. The first APD operational deployment is anticipated in March 2018 with additional releases and users being added over time.

INCREASE TRANSPARENCY TO EMPOWER CONSUMERS, PAYERS, AND PROVIDERS: REGIONAL OVERSIGHT MANAGEMENT COMMITTEES	
PILLAR 3.4	Increase adoption of Value-Based Insurance Design

SIM funding supported professional facilitation and convening services for each ROMC to support the design of these regional payment frameworks. Supporting the ROMCs to develop regional payment frameworks to operationalize APC and providing professional facilitation and convening services to ROMCs are important on-going efforts to increase the share of insurers using VBP models to 80%.

Separate payer only ROMC meetings were held in the Capital District/Hudson Valley ROMC and the Metro ROMC. The payer only meetings have a specific focus in all regions to develop a value-based payment model that would best fit the needs of each geographic region. In 2017 plans were asked to provide the data so that multi-payer results could be provided to more providers across the state. NYSDOH will be providing aggregate practice results to the insurers that provide data, and this may have benefits even for plans not participating in an APC regional committee. Insurers may benefit from developing the internal capacity to provide this type of measurement as they prepare to manage value-base payment arrangements.

OQPS and DFS continued to work together throughout the 2017 program year to increase payer participation in ROMC activities, and to use policy levers to support SHIP goals. OQPS met with DFS several times to discuss regulatory authority to support statewide evaluation of practice transformation efforts across commercial payers. OQPS also engaged OHIP in discussions about measuring and evaluating practice transformation to ensure alignment across multiple transformation initiatives.

Full ROMC committee meetings follow a similar path with groups consisting of local community of providers, payers, patients, purchasers and government working together to build a payment methodology that recognizes the up-front, un-reimbursed investment that practices must make to transform while simultaneously linking an advanced state of transformation to remuneration premised on quality and value.

INCREASE TRANSPARENCY TO EMPOWER CONSUMERS, PAYERS, AND PROVIDERS: CONSUMER ENGAGEMENT INITIATIVE	
Pillar 3.5	Continue to amplify best practices in self-management of chronic diseases

In 2016, OQPS developed several proposals for a SIM funded consumer engagement initiative to support APC. The Access and Consumer Engagement Project was selected for further review. The Access and Consumer Engagement Project will develop a public health campaign to: (1) encourage patients, the public and health care staff to be aware of the range of health care services available and to choose the right service at the right time, (2) educate the public on when, and when not, to use various types of ambulatory care providers and when to seek care at an emergency department, (3) raise public awareness of health care services and help the public link their needs to the right services to meet their health care needs including self-care, care from a pharmacist, primary care provider, retail clinic, urgent care or emergency department.

In 2017, OQPS developed three sub-proposals to implement the Access and Consumer Engagement Project. Proposals are centered on activities that engage and educate patients about APC, their expectations for care, and how to navigate care in a value-based health care system. Proposals also include activities to support and reinforce patient adoption of key elements of APC. Examples include advanced care planning, self-management of chronic conditions, and increasing patient engagement across health siloes.

Each proposal will be presented to, and reviewed by, SIM and SHIP stakeholders to support the selection of one proposal for implementation in the 2018 program year.

VALUE-BASED CARE

Under the SHIP, the detailed design and implementation of multi-payer models that support value-based care is the responsibility of payers, working with providers. The DFS health insurance premium Rate-Review process supports the timely transition to at least 80% penetration of value-based payment models. The State encourages broad use of value-based insurance design by helping to create transparency about best practices in VBID and encouraging broad based adoption of such practices across payers through ROMCs.

Traditional fee-for-service 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% of our health care dollars go to overtreatment, inefficiency, and fragmented care delivery.

Under SHIP, the shift from FFS to VBP rests on five elements:

- embrace value-based payment across primary care and specialty care for hospitals and other providers;
- establish a flexible framework for value-based payment for APC;
- adopt value-based payment for APC within both Medicaid and State and Public employees;
- encourage Medicare to make value-based payment for APC more universally accessible to providers; and
- align regulatory processes with adoption of value-based payment.

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PAY FOR VALUE NOT VOLUME: REGIONAL OVERSIGHT MANAGEMENT COMMITTEE MULTI-PAYER MODEL	
Pillar 4.1	Embrace value-based payment across primary care and specialty care for hospitals and other providers

ROMCs are comprised of an array of diverse stakeholders including patients, providers, and payers that support the adoption of value-based payment models across primary care and specialty care for hospitals and other providers. Payers that participate in each of the three ROMCs established in 2017 were engaged in a collaborative process through the ROMC to develop regionally specific multi-payer models. Ideally, these models represent an agreement among participating ROMC payers to use a unified set of core measures around which value-based payment contracts are based.

Two of the three NYS ROMCs began deliberations about the feasibility of multi-payer models specific to their regions. Payers met frequently during “payer only” meetings to discuss the design, development, and implementation of the models under consideration. Participating payers will continue their efforts to finalize model development and implementation in 2018.

PAY FOR VALUE NOT VOLUME: MEDICAID STATE PLAN AMENDMENT	
PILLAR 4.2	Establish a flexible framework for VBP under APC
PILLAR 4.3	Adopt value-based payment for APC within both Medicaid and State and Public Employees

In December 2016 NYSDOH submitted a Medicaid State Plan Amendment requesting an amendment to the NYS Medicaid Plan. The purpose of the SPA is to establish a framework for value-based payment for APC practices that demonstrate success in practice transformation. The SPA covers physicians, nurse practitioners, hospital-based clinics, freestanding clinics, and Federally Qualified Health Centers.

The SPA specifically proposes to improve access to high quality primary care services by providing incentive payments to entities that meet APC standards. Proposed incentive payments amounts align with established incentive payments for primary care services for both Medicaid Fee-For-Service and Managed Care. To maintain eligibility for incentive payments proposed in the SPA, covered entities must supply data to NYSDOH to evaluate the impact of APC on health care quality, outcomes, and cost.

As of December 31, 2017, the SPA remained under review by CMS and is pending approval.

PAY FOR VALUE NOT VOLUME: PUBLIC COMMENTS TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	
Pillar 4.4	Encourage Medicare to make value-based payment for APC more universally accessible to providers

CMS oversee two initiatives through which primary care physicians are eligible to receive payments for providing value-based care to Medicare patients. The programs were created under The Medicare Access and CHIP Reauthorization Act of 2015, bipartisan legislation signed into law on April 16, 2015. The Merit Incentive Payment System provides a performance-based payment adjustment to Medicare payments. Payment adjustments are based on evidence and practice-specific quality data provided by the practice to CMS. This rewards practices providing high quality, efficient care supported by technology.

The other approach is based on membership by practice in APMs. APMs are a payment approach that gives added incentive payments to providers that provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients' outcomes. Practices earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.

The primary mechanism through which NYSDOH encourages Medicare to make value-based payment for APC more universally accessible to providers is by aligning best practices and standards across each program. This acts to reduce burdens on providers who are required to participate in either MIPS or an Advanced APM and encourages providers to provide higher levels of care. APC was designed to align across the numerous, diverse, and at times confusing, landscape of initiatives to increase value-based payment arrangements in NYS. Alignment with federal initiatives such as MIPS and Advanced APM standards occurred during the design and implementation phases of APC. As each initiative continues to evolve, NYSDOH remains committed to advocating for federal alignment that increases value-based payments to APC practices. Often these efforts occur through public and private communications to CMS.

In 2017, NYSDOH issued two documents urging CMS to alter or maintain standards that align MIPS, advanced APMs, and APC. The first was a public comment in response to proposed changes to MIPS and advanced APMs under the MACRA legislation. In this response NYSDOH:

- urged CMS to recognize APC and NYS Medicaid Value-based Payment Arrangements as Advanced APMs highlighting both programs met the criteria established by CMS for recognition;

- encouraged CMS to allow clinicians excluded from MIPS under the proposed Low Volume Threshold the opportunity to electively participate in the program;

- recommended that Quality Improvement Scoring be adapted so that early adopters of practice transformation are not penalized, and larger investments

in practice transformation are recognized during later stages of practice transformation; and

- encouraged CMS to temporarily lower financial risk standards for the MIPS and Advanced APM entities to increase practice engagement in value-based payment arrangements.

The second document was a response to CMS Request for Information from states to inform the design of new models to increase health care transformation. Working across agencies, NYSDOH prepared a response that encouraged CMS, and Medicare particularly, to make value-based payment for APC more universally accessible to providers. NYSDOH specifically recommended the following models be developed under the authority of CMS, for development and implementation in NYS:

- a state-led Advanced APM;
- a state-led model aligning existing Medicaid and Medicare value-based payment arrangements;
- a state-led physician specialty model; and
- a state led model aligning Medicare and commercial value-based payment arrangements.

Each model described by the NYSDOH in the response reduces burdens on providers and improves the delivery of quality care by aligning New York's flagship value-based payment programs. Successes in New York's APC model are extended to other settings of care that are high-cost, including hospital and specialties.

NYSDOH will continue to advocate to make value-based payments for APC models more universally acceptable to providers.

PAY FOR VALUE NOT VOLUME: RATE REVIEW	
Pillar 4.5	Align regulatory processes with adoption of value-base payment

DFS is the key stakeholder in aligning regulatory process' to accelerate the adoption of value-based payments among New York State's public and private payers. DFS has been a member of the Health Innovation Council since it began, providing guidance on development and implementation of SHIP activities as the primary regulator of health insurers in New York.

DFS worked extensively with NYSDOH, public and private payers, and other stakeholders to analyze how New York's laws and regulations could be leveraged to enhance value-based payment participation among insurers. For example, DFS developed a model to credit insurers value-based payments in the medical loss ratio formula, which was then considered during the rate review process.

As part of these efforts, since 2015 DFS has collected data on insurers quality improvement expenses for rate review. For example, DFS has collected data about the overall percentage of value-based payment business across private payers. DFS and NYSDOH collaborated to measure the overall extent of value-based payment contracting across NYS, both in terms of percentage of members and percentage of participating providers covered under value-based payment contracts. The first survey resulted in the publication of the Catalyst for Payment Reform scorecard.

DFS also issues guidelines to support value-based payment arrangements related to risk-sharing provider contracts. In NYS, risk sharing arrangements between insurers and provider practices may trigger certain reserve and solvency requirements under applicable law to make sure the practices remain financially healthy as they take on more risk. DFS and DOH worked together to clarify applicable rules, make sure the two agencies were consistent, and provide a clear roadmap for insurers and provider practices entering risk sharing contracts.

As part of its annual review of health insurance premiums, DFS began collecting data on insurers' primary care spend and quality improvement expenses, which can inform insurer's progress towards value-based payment. DFS continues to work with NYSDOH to coordinate data collection and use cases for the APD. DFS works extensively with the APD team to coordinate data collection and use cases with insurance regulatory oversight. DFS continues to participate in the SHIP project as a member the New York City ROMC and advises the other ROMCs on an as needed basis.

POPULATION HEALTH

The SHIP recognizes that health and health care outcomes are influenced, if not determined, by factors outside the health care delivery system. SHIP uses the State Health Department's Prevention Agenda 2013–2018 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, SHIP works 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. The ultimate goal of the SHIP's population health pillar is to: (1) connect 90% of primary care practices to community-based organizations working to support population health through high-quality registries of community health-focused organizations, and (2) promote regional health planning.

The Prevention Agenda 2013-2018 sets out New York's comprehensive approach to population health and prevention and as such provides a pivotal backbone for the State Health Innovation Plan. APC plays a critical role 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.

Under SHIP, the strategy to connect primary care to population health improvement is segmented in five parts:

- strengthen local health planning and increase the involvement of primary care providers;
- develop population health reports and draw on Prevention Agenda community health plans, routinely integrating them with performance improvement efforts undertaken by APC practices;
- build and maintain community resource registries and ensure that APC practices have easy access to them;
- create a formal communication channel between the primary care community, local health planning stakeholders, and local Prevention Agenda partnerships; and
- ensure that care coordinators are experts in fostering community linkages.

PROMOTE POPULATION HEALTH-CONNECT PRIMARY CARE TO POPULATION HEALTH IMPROVEMENT: LINKING INTERVENTIONS FOR TOTAL POPULATION HEALTH (PROJECT LIFT)	
Pillar 5.1	Strengthen local health planning and increase the involvement of primary care providers.

The Linking Interventions for Total Population Health (Project LIFT) program funds community coalitions to come together around one chosen Prevention Agenda issue and includes primary care practices. These coalitions implement a spectrum of coordinated and linked prevention activities (i.e., traditional clinical preventive interventions, innovative clinical preventive interventions that extend outside the clinical setting, and total population or community-wide interventions) that focus on one of the five issues specified below related to the Prevent Chronic Disease priority areas of the New York State Prevention Agenda 2013-18 (Prevention Agenda): (1) Prevent and Control Obesity and Diabetes, (2) Prevent and Reduce Tobacco Use, (3) Prevent Cardiovascular Disease and Control High Blood Pressure, (4) Reduce and Control Asthma, (5) Prevent and Detect Cancer.

In 2016, a RFA was released to support up to five locally-based projects that bring together health care, public health, and community organizations to address community health improvement goals by implementing prevention approaches across distinct categories including: (1) traditional clinical prevention (2) innovative clinical prevention, and (3) total population or community-wide prevention. These areas constitute the three "buckets" of prevention, a model that acknowledges that common health improvement goals can be best achieved through coordination and collaboration across all sectors involved in protecting and improving health.

These community-based projects 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 New York's Prevention Agenda.

2017 Updates: Six contracts were competitively procured in 2017, covering 18 counties. Table 9 below describes the contractors; prevention agenda focus areas, and counties covered.

TABLE 9: Linking Interventions for Total Population Health (LIFT)

Contractor Name	Prevention Agenda Focus Area	NYS Counties
University of Rochester Center for Community Health	Prevent and Control Obesity and Diabetes	Monroe
S2AY Rural Health Network, Inc.	Prevent and Control Obesity and Diabetes	Chemung; Livingston; Ontario; Schuyler; Seneca; Steuben; Wayne; Yates
P2 Collaborative of Western New York	Prevent and Control Obesity and Diabetes	Erie; Niagara; Orleans; Genesee
HealthlinkNY	Prevent and Control Obesity and Diabetes	Orange
Fort Drum Regional Health Planning Organization, Inc.	Prevent and Control Obesity and Diabetes	Jefferson; Lewis; St. Lawrence
Fund for Public Health in NYC	Prevent Cardiovascular Disease and Control High Blood Pressure	Kings

PROMOTE POPULATION HEALTH-CONNECT PRIMARY CARE TO POPULATION HEALTH IMPROVEMENT: APC POPULATION HEALTH MILESTONES	
PILLAR 5.2	Develop population health reports and draw on Prevention Agenda community health plans, routinely integrating them with performance improvement efforts undertaken by APC practices
PILLAR 5.3	Build and maintain community resource registries and ensure that APC practices have easy access to them
PILLAR 5.5	Ensure that care coordinators are experts in fostering community linkages

Population health in New York is guided by the State's Prevention Agenda 2013-2018. The Prevention Agenda was developed in 2012 by NYSDOH and a committee made up of a diverse set of stakeholders including local health departments, health care providers, health plans, community-based organizations, academia, employers, state agencies, schools and businesses. The Prevention Agenda has five priorities:

- prevent chronic disease;
- promote healthy and safe environments;
- promote healthy women, infants and children;
- promote mental health and prevent substance abuse; and
- prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare Associated Infections.

Each priority area has an action plan that identifies goals and indicators to measure progress and recommended policies and evidence-based interventions using the National Prevention Strategy, Guide to Community Preventive Services, and other sources.

The Prevention Agenda is embedded in APC to increase the involvement of primary care providers, and to increase their capacity to engage with public health activities. In this way, a formal communication channel between primary care community, local health planning stakeholders, and local Prevention Agenda partnerships is created.

Population health milestones that were built into the APC model to support pillars include:

- identification and outreach to patients due for preventive or chronic care management as needed/appropriate;
- process to refer to self-management programs and community-based resources; and
- participate in at least two Prevention Agenda activities annually in conjunction with county health departments.

The Prevention Agenda served as a guide to local health departments as they developed their mandated Community Health Assessments, which included a Community Health

Improvement Plan, and to hospitals as they developed mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act. Local health departments and hospitals were asked to collaborate with each other and community partners on the development of these documents and to identify at least two priorities from the Prevention Agenda. For each priority, local health departments and hospitals identified goals and objectives, improvement strategies and performance measures with measurable and time-framed targets over the plan period.

The Prevention Agenda continued to serve as a valuable resource to strengthen local health planning. Progress on the Prevention Agenda is tracked using a dashboard available on the NYSDOH public website. The New York State Prevention Agenda Dashboard is an interactive visual presentation of the PA tracking indicator data at state and county levels. The state dashboard homepage displays a quick view of the most current data for New York State and the 2018 objectives for approximately 100 tracking indicators. The most current data are compared to data from previous time periods to assess the performance for each indicator. Historical data can be easily accessed, and county data are also available for each tracking indicator. The county dashboard homepage includes the most current data available for 68 tracking indicators. Each county in the state has its own dashboard. The Dashboard can be found at:

https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/.

While community resource registries have not been developed, several initiatives to improve linkage between population health resources and APC practices have been developed. For example, OPH developed a template for APC practices to use to develop local/regional resource guides to satisfy requirements of the APC Model. Additionally, the SIM Population Health team held a webinar in April 2017 for APC practices on the topic of Community-Clinical Linkages. The speaker was a Quality Improvement Advisor for a large health systems agency and a licensed social worker.

PROMOTE POPULATION HEALTH-CONNECT PRIMARY CARE TO POPULATION HEALTH IMPROVEMENT: POPULATION HEALTH IMPROVEMENT PROGRAMS (PHIPS)	
PILLAR 5.4	Create a formal communication channel between primary care community, local health planning stakeholders, and local Prevention Agenda partnerships

The Population Health Improvement Program promotes the Triple Aim – better care, better population health, and lower health care costs – through the work of 11 regional lead organizations that collectively cover the state. The program supports the lead organizations, often referred to as "PHIPs," in convening stakeholders and establishing neutral forums to identify, share, disseminate and help implement best practices and strategies to promote population health and reduce health care disparities in their respective regions. PHIPs help support and advance ongoing activities related to the New York State Prevention Agenda 2013-2018 and the State Health Innovation Plan (SHIP) and serve as resources to DSRIP PPSs.

In 2017, PHIPs continued their work engaging stakeholders in collaborative strategic planning, performing data analytics that inform regional activities, and communicate progress and share resources with the public. In support of the Prevention Agenda, PHIPs also participated in ongoing meetings of the Public Health and Health Planning Council's Ad Hoc Committee to Lead the Prevention Agenda, and assisted with updating county Community Health Needs Assessments, Community Health Improvement Plans, and Community Service Plans that fulfill state and federal requirements for local health departments and hospitals. In support of the SHIP, PHIPs continued to serve as resources for information about the development of APC and its expected impact on regional activities. PHIPs also continued to identify opportunities to assist DSRIP PPS in their respective regions including, for example, collaborating on initiatives to promote health literacy and cultural competency. In addition, PHIPs participated in behavioral health Regional Planning Consortiums, a network of 11 regional boards led by the New York State Conference of Local Mental Hygiene Directors that informs regional behavioral health policy and identifies solutions to regional service delivery challenges.

PHIPs also conducted region-specific activities in support of regional population health priorities. For example, PHIPs continued to promote a variety of approaches to preventing and managing chronic disease by supporting initiatives such as blood pressure self-management programs and tobacco cessation activities. Some PHIPs focused on addressing high obesity rates by coordinating and promoting walking initiatives or by offering data and technical assistance to local "Complete Street" initiatives that facilitate safe walking and biking for people of all ages and abilities. A number of PHIPs also emphasized behavioral health through endeavors such as promoting the Mental Health First Aid Model or working with stakeholders on development of anti-stigma campaigns to encourage people to seek mental health services.

CROSS CUTTING ENABLERS

While some of the cross-cutting enablers identified in SHIP contribute to more than one strategic pillar, such as workforce development, some enablers have been developed into stand-alone programs that provide the knowledge, tools, or technology to support health care transformation across NYS.

Health Information Technology: The near and long-term success of the SHIP rests squarely on the extent to which HIT can effectively evolve and be integrated into New York's health care system. Through SHIP, New York committed to plans that 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.

New York continues to advance the following HIT strategic priorities under the SHIP:

- encourage the adoption of certified EHRs, including the participation in Meaningful Use by eligible providers and hospitals;

- promote provider participation in bidirectional HIE with SHIN-NY by substantially decreasing the cost of participating in HIE by:

    - leading the development of interoperability standards for EHRs, thereby substantially decreasing the cost of connecting to the HIE;
    - applying for waiver and other funds to assist with the costs and process of connecting to the HIE; and
    - creating a public utility model to eliminate ongoing interface costs and provide new tools for providers.

- implement APD to better assess health and health care across New York and inform planning, program/policy development, and evaluation through analytics and visualization tools;

- 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;

- make government datasets (cleansed of personally identifiable information) publicly available to encourage transparency and innovation in research and discovery; and

- 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.

Performance Measurement and Evaluation: The SHIP is a significant undertaking at multiple levels and depends on the participation of diverse stakeholders. Therefore, the approach to

measurement and evaluation captures the breadth, depth, and complexity of the SHIPs ambitions, establishes evidence of positive or negative impact, and generates insights to fuel future improvements to the SHIP.

The broad approach is based on four guiding principles:

- measure the progress of transformation as well as the impact against the Triple AIM;
- build from existing efforts while standardizing where possible to reduce provider burden and increase comparability;
- enhance transparency to consumers, communities, providers, payers, and the State; and
- emphasize rapid cycle evaluation over long term academic evaluation.

HEALTH INFORMATION TECHNOLOGY: SHIN-NY CONNECTIONS INITATIVE	
ENABLER B.1	Encourage the adoption of certified EHR

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 HIE such as the SHIN-NY. 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. There are additional costs associated with connecting to the HIE.

Beginning in 2006, the Health Care Efficiency and Affordability Law for New Yorkers 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. 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 Regional Extension Centers 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. 67% of primary care providers had EHRs as of 2015, although only a portion of these are certified EHRs or used meaningfully. Specifically, only 48% of primary care providers use EHRs for prescriptions, labs, and notes.

To decrease barriers using certified EHRs in NYS, NYSDOH with support from CMS, established the SHIN-NY Connections Initiative. The Initiative increases health information exchange adoption by primary care practices across the State and assists them in meeting the APC milestones. Building EHR interfaces to QEs increases the quantity and quality of data in the SHIN-NY and builds value for providers and patients at the point of care. This program is designed to help defray the cost for APC-enrolled primary care practices when connecting to their local QE.

The Initiative became available for APC-enrolled primary care practices on 12/1/2017. Eligibility criteria for participation are described here.

Primary care organizations that meet the conditions of participation are eligible to receive "Milestone Payments" that help defray the costs of using EHR technology and encourage adoption of certified EHR technology among primary care practices.

HEALTH INFORMATION TECHNOLOGY: SHIN-NY	
ENABLER B.2	Promote provider participation in bidirectional HIE with the 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.

NYS created the SHIN-NY to allow the electronic exchange of clinical information and connect health care professionals statewide. The SHIN-NY enables collaboration and coordination of care to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs**.** The SHIN-NY is overseen by the NYSDOH and governed by privacy and security policies and standards. The SHIN-NY is administered by the New York eHealth Collaborative, a NYS designated entity.

Patient information in the SHIN-NY is protected under HIPAA, other applicable federal and state laws, and national data exchange standards, making data safe and secure. A QE, also referred to as a regional health information organization, is a regional network where electronic health information is stored and shared. There are eight QEs in New York, each enrolling participants within their community, including those from hospitals, clinics, Federally Qualified Health Centers, home care agencies, payers, and ambulatory practices, among others, providing core services so they can access and exchange electronic health information with participants in their region.

The SHIN-NY connects the eight QEs, allowing participating health care professionals, with patient consent, to quickly access electronic health information and securely exchange data statewide.

Today, the SHIN-NY connects 98% of hospitals in New York State, over 80,000 medical providers, and represents millions of people who live in or receive care in New York. In 2017, OQPS began to update the translation process, verification, conversion, editing and validating processes of SHIN-NY to be more aligned with the APD platform. OQPS will continue to work to plan and develop capabilities for the intake officially generated inpatient data into the APD. Greater alignment will increase the capacity for the data to be used to support and protect the health of New Yorkers through more effective information exchange.

More information about SHIN-NY is available here.

HEALTH INFORMATION TECHNOLOGY: HEALTH DATA NY	
ENABLER B.6	Make government datasets (cleansed of personally identifiable information) publicly available to encourage transparency and innovation in research and discovery

NYSDOH has been making it easier for New Yorkers to find and use state health information. The open data website, Health Data NY, launched in March 2013 with data about restaurant inspections, hospital bed availability, and hospital-acquired infection rates. Since 2013, the site has grown to over 150 health-related datasets on over 80 topics, undergone a redesign, and won a national innovation award at the annual Health Datapalooza held in Washington, DC.

Health Data NY is the first state-run open data site in the U.S. dedicated exclusively to health data. It is part of Governor Cuomo's data transparency initiative, Open NY. Health Data NY doesn't just post spreadsheets of data, it offers comprehensive metadata and visualizations to ensure users understand the data. Most of the data on the site has preset filtering and sorting functionality, which assists users with analyzing the data. This improved transparency helps New York State communicate to its citizens how state programs are making an impact, and helps those citizens hold the state accountable for its health policies and services. New Yorkers can compare themselves to residents of other states, as well as review local data by county or region, highlighting issues like obesity and environmental toxicity.

New datasets were routinely added and updated on the healthdata.ny.gov website throughout the 2017 program year. In 2017, Health Data NY saw 178,716 unique users, a 16% increase from 2016. The highest total number of users in one week was 10,900.

PERFORMANCE MEASUREMENT AND EVALUATION: APC SCORECARD	
ENABLER C.1	APC Scorecard

As part of its initiative to integrate service delivery and reimbursement in NYS by implementing APC, NYSDOH has developed, tested, and disseminated a common set of core quality measures relevant to APC participating payers and practices. APC core measures reported as part of the APC Scorecard enables practices to view their performance across a common measure and multiple payers for the first time. In addition, measure results may be used by payers to inform outcomes-based payments and to provide valuable information about statewide progress towards multi-payer VBP adoption.

The NYSDOH's intention is to leverage the department's APD as the eventual source for calculating measure results, but in the interim period (2017-2019), the best option was to utilize the plans' current quality measure reporting operations with the capability to report using administrative data. Health plans submitted HEDIS/QARR data for all product lines (Commercial, Medicare, Medicaid) as the basis for measure calculation, with plans' methodology of member attribution to a provider and provider attribution to a Taxpayer Identification Number, which serves as the definition of a practice for reporting purposes. Data is aggregated across plans and a rate is calculated for each measure at a TIN-level to produce a practice-level performance score. Statewide and product line benchmarks were calculated to provide performance comparison both at a statewide level and for the product line composition a practice may have. Other sub-group analyses can be conducted, including analyses to assess regional and practice type differences.

The APC core measure set consists of 28 nationally endorsed administrative and hybrid measures, including one survey measure. All measures are described in Figure 4. Measures included in the Scorecard Version 1 issued in 2017 are checked.

The measures are intended to eventually form the basis for outcomes-based payments by payers, bringing greater alignment in measurement, reducing administrative burden, and amplifying the impact of value-based incentive payments.

In the interim period, NYSDOH released Version 1 of the APC Scorecard in late 2017. Version 1 consisted of 13 claims-based measures, including: Antidepressant Medication Management, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Childhood Immunization Status (Combo 3), Comprehensive Diabetes Care: HbA1c Testing, Comprehensive Diabetes Care: Eye Exam, Comprehensive Diabetes Care: Medical Attention for Nephropathy, Initiation and Engagement of Alcohol and other Drug Dependence Treatment, Medication Management for People with Asthma, Persistent Beta Blocker Treatment after Heart Attack, and Use of Imaging Studies for Low Back Pain.

In 2017, NYSDOH contracted with the New York State Technology Enterprise Corporation to develop a plan to leverage HIT to integrate Clinical Quality Measures into future versions of the APC Scorecard. Planning focused on how to leverage HIT and HIE to support quality measurement particular to health care transformation initiatives, such as DSRIP, SIM, and SHIP. To support transformation efforts such as these, HIEs are shifting from a focus on data

exchange towards data aggregation to meet use cases that involve looking at a patient's entire continuum of care or looking at services or health status across populations. Clinical Quality Measures are a critical component to evaluating new payment models, such as shared savings and pay for performance, that are being tested to transform a fee-for-service system into a value-based-payment system.

FIGURE 4: ADVANCED PRIMARY CARE SCORECARD CORE MEASURE SET

Domains	NQF #/Developer	Version 1 /Data Source	Measures	Version 1 (2017)	Version 2 (2018)
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 (Combo 3)	✓	✓
	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		✓
	1768/HEDIS	Claims	Plan All Cause Readmissions		
	--/HEDIS	Claims	Emergency Department Utilization		✓
	--/HEDIS	Claims	Outpatient Utilization		✓
Cost	--	Claims	Total Cost Per Member Per Month		

SECTION 4: 2017 STATE INNOVATION MODEL EXPENDITURE UPDATES

Under SHIP, SIM funding is used to accelerate health care transformation by funding initiatives and programs that support SHIP pillars and enablers. The first and second years of SIM funding were used to support project start-up, planning, and preliminary implementation of the SIM funded programs and initiatives described in this annual report. Significant delays in full implementation of SIM funded programs and initiative occurred in year 3 (2017) due to delays including longer than expected review and approval process' from the funding agencies. Consequently, SIM funds were not expended as planned.

To address this issue and to ensure that project funds remained available to support planned SIM activities under the SHIP, OQPS worked closely with the funder to apply for a "No-Cost Extension" of the SIM project. A twelve (12) month No-Cost Extension has been granted by the Centers for Medicare & Medicaid Innovation (CMMI) to ensure completion of SIM activities originally approved in Award Year 3. The No-Cost Extension effectively extends the SIM project for an additional year. This allows funds that were planned for disbursement in 2017 to be used in the 2018 program year. Only activities that were planned for 2017, or have been specially approved by CMMI, may be completed during the No-Cost Extension. Table 12 provides an overview of the award to date expenditures for the 2017 SIM program year.

TABLE 12: OVERVIEW OF 2017 STATE INNOVATION MODEL EXPENDITURES[14]

Category	Award to Date Expenditures- 02/01/2017-12/31/2017
Salaries	$1,127,114.39
Fringe Benefits	$387,807.41
Equipment	$0.00
Supplies	$75,978.73
Travel	$8,231.48
Services	$12,747.04
Contractors	$8,065,796.91
Miscellaneous	$4,185.00
Indirect Costs	$359,327.92
TOTAL	**$10,041,188.88**

SIM Expenditures for 2017 include that salaries of project specific OQPS staff and fringe benefits for staff. Equipment, supplies, and travel to support SIM program activity are also reported. Contracts supporting SIM drivers are the largest expenditure for the 2017 program year. Table 13, below, provides a detailed breakdown of contract expenditures by SIM driver.

[14] The SIM grant award year runs from February 1, 2017 through January 31, 2018. To ensure incremental expenditures and successful implementation of all contracted programs, NYSDOH has been granted a No-Cost Extension by CMMI, the federal sponsor. The following tables note a breakdown of the categorical expenses (Table 12); detail of expenditures by SIM Drivers; and, an additional column reflecting the expected expenses to be incurred by end of No-Cost Extension date (Table 13).

TABLE 13: STATE INNOVATION MODEL EXPENDITURES BY DRIVER

Category	Award to Date Expenditures 02/01/2017-12/31/2017	Expected Expenditures NCE 02/01/2017-01/31/2019
Global Contracts	$1,838,825.00	$6,000,000.00
Driver I- Access to Care Contracts	$0.00	$850,000.00
Driver II- Integrated Care	$3,614,467.97	$21,359,995.00
Driver III-Transparency, Evaluation and Health Information Technology (HIT) Contracts	$2,400,113.43	$5,763,500.00
Driver IV-Population Health Contracts	$0.00	$1,896.000.00
Driver V-Workforce Contracts	$212,390.51	$760,205.00
TOTAL	**$8,065,796.91**	**$36,798,588.00**

Expenditure categories: SIM expenditures are grouped into seven discrete categories. Six of the seven categories align with the SIM drivers including: (1) access to care, (2) integrated care payment, (3) integrated care evaluation, (4) transparency, evaluation and health information technology, (5) population health, and (6) workforce. The seventh category, global contracts, represent overarching contracts that support the completion of SIM goals across multiple drivers.

APPENDIX 1: ACRONYMS USED IN SHIP REPORT

ACRONYM	DEFINITION
APC	Advanced Primary Care Model
APC Scorecard	Advanced Primary Care Scorecard
APD	All-Payer Database
APM	Alternative Payment Model
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
CPCi	Comprehensive Primary Care initiative
DCS	Department of Civil Service
DFS	Department of Financial Services
DOB	Department of Budget
DSRIP	Delivery System Reform Incentive Payment Program
FFS	Fee For Service
GME	Graduate Medical Education
HEDIS	Healthcare Effectiveness Data and Information Set
HER	Electronic Health Records
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITRUST	Health Information Trust Alliance
HRI	Health Research, Incorporated
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit Incentive Payment System
NCQA	National Committee for Quality Assurance
NYeC	New York eHealth Collaborative
NYS PCMH	New York State Patient Centered Medical Home Model
NYSDOH	New York State Department of Health
NYSoH	New York State of Health
OASAS	Office of Alcoholism and Substance Abuse Services
OHIP	Office of Health Insurance Programs
OMH	Office of Mental Health
OPCHSM	Office of Primary Care and Health Systems Management
OPH	Office of Public Health
OQPS	Office of Quality and Patient Safety
PCMH	Patient Centered Medical Home
PHIP	Population Health Improvement Program

ACRONYM	DEFINITION
PPS	Delivery System Reform Incentive Payment Program Performing Provider Systems
Project ECHO®	Project Extension for Community Healthcare Outcomes
PT TA	Practice Transformation Technical Assistance
PTTS	Practice Transformation Tracking System
QARR	Quality Assurance Reporting Requirements
QE	Qualified Entity
RFA	Request for Applications
RFI	Request for Information
RFP	Request for Proposals
ROMC	Regional Oversight Management Committee
SHIN-NY	The Statewide Health Information Network for New York
SHIP	State Health Innovation Plan
SPA	State Plan Amendment
SPARCS	State Planning and Research Cooperative System
VBP	Value-Based Payments

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