IMPLEMENTATION OF THE NEW YORK STATE HEALTH INNOVATION PLAN

Annual Report: 2018

Contents

EXECUTIVE SUMMARY 3

SECTION I: BACKGROUND....5

SECTION II: WORKGROUP RECOMMENDATIONS 8

Health Innovation Council....8

Integrated Care Workgroup 8

Statewide Steering Committee 8

Workforce Workgroup....9

HIT, Evaluation, and Transparency Workgroup 12

SECTION III: YEARLY PROGRESS TOWARDS SHIP GOALS....13

Access to Care....18

Integrated Care for All 27

Transparency 35

Value-Based Care....42

Population Health....47

Cross Cutting Enablers....54

Health Information Technology....54

Performance Measurement and Evaluation....54

SECTION IV: 2018 STATE INNOVATION MODEL EXPENDITURE UPDATES 61

APPENDIX 1: ACRONYMS 62

EXECUTIVE SUMMARY

The mission of the New York State Health Innovation Plan (SHIP) 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.

Five years ago, the New York State Department of Health, Department of Financial Services (DFS), Department of Civil Service (DCS), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS) worked collaboratively across agencies to develop the SHIP, 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 2018, moving New York closer to achieving the promise of the SHIP. Accomplishments include: (1) the launch of the New York State Patient Centered Medical Home (NYS PCMH) Model in April 2018; (2) 1,800 primary care practices that have begun the process of practice transformation since the launch, transitioning from care delivery 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 Committees (ROMC) 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 SHIP goals in the 2018 program year. Four sections describe the:

- background on the SHIP and the State Innovation Model (SIM);

- recommendations from workgroups and committees governing the SHIP;
- reports on progress towards achieving SHIP goals; and
- a report on SIM 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 NYS PCMH, 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. NYS PCMH 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 advanced primary care 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.

New York State Innovation Model

NYS applied for a Model Testing Grant through the Center for Medicare and Medicaid Innovation (CMMI) in September 2012.[2] 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

[1] The full State Health Innovation Plan is available on the New York State Department of Health website.
[2] NYSDOH published the Round 2 SIM application on their website.

activities in December 2014.[3] 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 NYS PCMH and related initiatives.[4] 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 (OQPS). Within OQPS, the Division of Health Care Innovation (DHCI) 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, Division of the Budget (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. Strong, formal mechanisms for these stakeholders to inform the direction and progress of SHIP include:

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

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

(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 NYS PCMH 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, DHCI 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 (SHIN-NY).

DHCI works closely with the Office of Health Insurance Programs (OHIP), DFS, Office of Public Health (OPH), Office of Primary Care and Health Systems Management (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

In early 2015 three workgroups were organized 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[5]*:* 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 2018. There are currently no recommendations for legislative consideration.

Integrated Care Workgroup[6]**:** The Integrated Care Workgroup was established in 2015 to:

- create a vision 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.

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.

Statewide Steering Committee[7]**:** As a multi-stakeholder group, the Statewide Steering Committee serves as the neutral convener of the New York State NYS PCMH model. Committee

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

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

- advising the NYSDOH on the evolution of the NYS PCMH 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 2018 program year include oversight and support of:

- statewide evaluation of SIM by CMMI;
- overseeing the implementation of expanded practice transformation assistance to accelerate practice enrollment in NYS PCMH;
- monitoring three ROMCs in the Capital District/Hudson Valley, Metro, and Finger lakes regions;
- collaboration with the Adirondack ROMC;
- provide stewardship over the NYS Primary Care Core Measure Set;
- consumer engagement initiatives;
- post-SIM sustainability planning;
- Health Information Technology (HIT) enabled quality measurement; and
- Producing and disseminating the Primary Care Scorecard.

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

Workforce Workgroup[8]: 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 (DSRIP) Program Performing Provider Systems (PPS) Panel

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

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;

- 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; and

- Developing a compendium of best health care workforce practices that contains tools and resources which interested parties can replicate and utilize for their workforce transformation purposes.

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

TABLE 1: WORKFORCE WORKGROUP SUBCOMMITTEES

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.	The collection of enhanced data from all licensed health care practitioners upon registration and re-registration with the State Health Department (SED). Consistent with that recommendation, NYSDOH proposed legislation to incorporate additional information into the publicly available Physician Profile. (The enhanced data collected would be used to improve tracking of workforce trends and would help inform policy decision.)
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[9]: The HIT, Evaluation and Transparency Workgroup was formed in 2014 and continued to meet throughout 2018. The workgroup mandate is to:

- evaluate NYS HIT infrastructure and systems as well as other related plans and projects including but not limited to the All Payer Database (APD), SHIN-NY, and the State Planning and Research Cooperative System (SPARCS);
- 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 NYS Primary Care 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 2018 program year include oversight and support of:

- the NYS Primary Care Scorecard 2.0;
- Qualified Entity (QE) Quality Measurement Pilot;
- VBP Pilot Quality Measure Testing Project; and
- NYS Health Connector.

Workgroup recommendations: The HIT, Evaluation and Transparency Workgroup met during 2018, but has no recommendations for legislative consideration.

[9] 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 2018. 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.[10] 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.

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

TABLE 2: 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 safety-net providers that serve New York's most vulnerable populations, regardless of ability to pay.	OHIP	No
1.3	Increase workforce capacity in rural and 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 a universal model for statewide, multi-payer adoption (NYS PCMH).	OQPS	Yes
2.2	Promote consistent standards and expectations for NYS PCMH 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 a NYS PCMH 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*[11]
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		
3.1	Deploy a New York State consumer transparency portal.	OQPS	No
3.2	Create a patient portal.	OQPS	No

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

	Pillar	Owner	SIM Funded
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
	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 VBP under NYS PCMH.	OQPS/OHIP	Yes
4.3	Adopt value-based payment for advanced primary care within both Medicaid and State and Public Employees.	OQPS/OHIP/DCS	Yes*
4.4	Encourage Medicare to make value-based payment for NYS PCMH 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 NYS PCMH practices.	OPH/OQPS	Yes*
5.3	Build and maintain community resource registries and ensure that NYS PCMH 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 NYS PCMH 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/OPCHSM	Yes
A.4	Develop more robust working data, analytics, and planning capacity throughout New York.	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 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.	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*

	Enabler	Owner	SIM Funded
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.	OQPS	No
B.7	Enable the operation of the NYS PCMH model by providing support for NYS PCMH recognition as well as any new resources needed for progress tracking and evaluation.	OQPS	Yes
	Performance Measurement and Evaluation		
C.1	Primary Care Scorecard/HIT Enabled QM.	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 SHIP's 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 (NYSoH) MARKETPLACE	
PILLAR 1.1	Leverage consumer insights to increase adoption of health insurance coverage

New York State of Health (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 2018 enrollment through NYSoH reached its highest point reported to date. As of January 31, 2019 enrollment through NYSoH reached over 4.7 million – exceeding enrollment from the previous year by 435,000. New York has seen a significant, corresponding reduction in the number of uninsured, from 10% in 2013 when the Marketplace opened to under 5% at the end of 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 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 and Medicaid Services (CMS) to deliver innovative models of care for its Medicaid members through a 1115 waiver. More than five 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 the 25 PPS have successfully implemented over 95% of their Year 3 project requirements and earned 86% of the available funds through Demonstration Year 3.

The DSRIP program has helped to enhance the safety net foundation by incentivizing PPS to assist Medicaid primary care providers to reach the highest levels of the National Committee for Quality Assurance's Patient-Centered Medical Home (NCQA PCMH) 2014 Level 3 recognition and New York State PCMH standards. These enhanced standards include behavioral health care coordination, clinical information exchange, and other care coordination functions, thereby facilitating integration of comprehensive care within the community. There are now approximately 9,000 PCMH-recognized practitioners state-wide at the higher NCQA PCMH and NYS PCMH level.

A critical component of the State's DSRIP program, and value-based payment (VBP) transition, is the role of social determinants of health and community-based organizations. In fact, the New York State Roadmap for Medicaid Payment Reform[12], which intends to establish a sustainable model for health care delivery, requires social determinants of health and community-based organizations be included in provider networks that engage in progressive levels of shared savings and risk arrangements. Through this inclusion, safety-net providers will be strengthened in serving the most vulnerable populations. The Roadmap specifically recognizes that addressing the social determinants of health is a critical element in successfully meeting the goals of DSRIP and VBP. 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.

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

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.

DSRIP is transforming care delivery in NY and VBP is intended to sustain those transformations by rewarding measures achieved through DSRIP. This will strengthen safety-net providers by compensating them for broadening networks and delivering high value care at lower costs. More information about DSRIP is available on their website here: https://www.health.ny.gov/dsrip/.

ACCESS TO CARE: PROJECT ECHO®	
PILLAR 1.3	Increase workforce capacity in rural and 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 and underserved 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 rural and underserved areas.

In 2017, building on the proven Project ECHO® model, the SIM team developed and released a Request for Proposals (RFP) to identify and fund up to four hub sites in New York. Four hub sites were identified, and preliminary contracts and work plans were developed with each hub site. Full implementation of the Project ECHO® portion of the SIM plan started in 2018.

In the 2018 project year the following activities were completed:

- ECHO hub site certification;
- Ongoing outreach and recruitment of spoke sites;
- Certification of spoke sites to begin participation in the Project ECHO sessions;
- Establishment of six Hub topic areas through curricular development; and
- Implementation of teleECHO clinical sessions.

More information about regional Project ECHO® activities is provided in Table 3 below. The table lists the contractors, health focus areas, coverage areas for the project, and number of certified spoke sites (primary care providers) recruited. All contracts listed below were awarded following a competitive procurement process. The activities conducted by each contractor enhance the capacity of the primary care workforce throughout NYS; better equip primary care clinicians to meet the demands of NYS PCMH practice; provide timelier access to high-quality, team based primary care and reduce unnecessary referrals to specialists.

TABLE 3: Project ECHO® Sites

Contractor Name	Health Focus Areas	NYS Counties	Number of Certified Spoke Sites
SUNY Upstate Medical University	Endocrinology/Diabetes Prevention, Evaluation, Treatment and Management	Broome; Cayuga; Chemung; Chenango; Cortland; Herkimer; Jefferson; Lewis; Madison; Oneida; Onondaga; Oswego; Otsego; Seneca; St. Lawrence; Tioga; Tompkins	28
Westchester Medical Center Health Network	Behavioral Health	Westchester; Delaware; Dutchess; Orange; Putnam; Rockland; Sullivan; Ulster	19
Montefiore Medical Center	Alzheimer's and Dementia; Opioid Use Disorder Treatment for Prescribers; Opioid Use Disorder Treatment for Non-Prescribers; and Complex Care	Bronx; Dutchess; Orange; Putnam; Rockland; Sullivan; Ulster; Westchester	49
Champlain Valley Physicians Hospital	HIV and Hepatitis C	Clinton; Essex; Franklin; St. Lawrence	24

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 Graduate Medical Education (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 Request for Applications (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. In the 2018 program year, two contract recipients, Arnot Ogden Medical Center and Champlain Valley Physicians Hospital, successfully implemented their contracts. They achieved full accreditation for their rural residency training programs from the Accreditation Council on Graduate Medical Education (ACGME) and started training medical residents. The three remaining contract recipients completed or were in the process of completing the following activities to successfully implement the contracts:

- 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 NYS PCMH practice transformation activities;
- provide evidence of progress towards completing ACGME 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 4, 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 4: 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: NYS PCMH ACCESS TO CARE COMPETENCIES	
PILLAR 1.4	Make care more accessible through extended hours, open access scheduling, and use of technology.

NYS PCMH (described under Pillar 2.1) was developed to include concrete standards and expectations for progress through practice transformation. NYS PCMH makes care more accessible by requiring that enrolled practices offer open access scheduling and use technology to improve patient access to care. Under NYS PCMH 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 Emergency Department vs. office visits); and

- satisfy at least 80% of practice demand for same-day scheduling.

At the end of 2018, 1,515 primary care practices across NYS enrolled in the NYS PCMH program. Of those sites, 1,140 (75%) chose to work with a SIM-funded Transformation Agent contractor (representing 48% of the originally proposed 2,400 practices the agents estimated they would be able to assist over the life of their contracts). Additionally, 195 practices have successfully received NYS PCMH recognition affirming their commitment to New Yorkers' access to care.

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 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 NYS PCMH, 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 advanced primary care as a universal approach for statewide, multi-payer adoption;
- promote consistent standards and expectations to achieve fully integrated care within NYS PCMH;
- 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 a universal model for statewide multi-payer adoption (NYS PCMH).

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 VBP 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 an 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 VBP. 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.

In April 2018, NYS transitioned its care delivery model from APC to NYS PCMH. The complexity generated by multiple active primary care transformation programs in the State had been an ongoing challenge to achieving objectives sought by NYSDOH. To reduce the complexity surrounding multiple transformation initiatives in NYS, the Department collaborated with NCQA, the creator of the nation's leading PCMH program, to create a customized PCMH model that integrated the goals and desired outcomes of the APC model. NCQA's PCMH Recognition Program is the most widely adopted Patient-Centered Medical Home evaluation program in the country. More than 12,000 practices (with more than 60,000 clinicians) are recognized by NCQA and more than 100 payers support NCQA recognition through financial incentives or coaching.

The NYS PCMH model is intended to help primary care practices in NYS: (1) improve patient-centered access and patient experience; (2) perform comprehensive health assessments to identify patient needs; (3) deliver better preventive care such as immunizations and cancer screenings; (4) prioritize comprehensive care management to keep chronic conditions under control; (5) coordinate with other clinicians involved in patient care and close referral loops to

improve continuity and avoid gaps; and (6) identify patients who require recommended interventions and patients who need medication monitoring.

To enroll in NYS PCMH a practice may work on their own or with a Transformation Assistance contractor to begin applying the standards to the practice. The entire recognition process is managed through the Quality Performance Assessment Support System (Q-PASS), a user-friendly, online platform that allows for the upload of documentation, tracking of progress and management of practice sites and clinicians.

To support the efforts required in transforming New York practices to this new, exclusive model of patient care, NYSDOH provides the following resources:

Recognition at no cost to practices: NYSDOH covers the first year NYS PCMH Recognition fee or the first NYS PCMH Annual Reporting fee. The practice is responsible for paying their Annual Reporting fee each year after earning NYS PCMH Recognition.

Transformation assistance: NYS contracts with 15 organizations that specialize in NYS PCMH transformation and are available at no cost to participating practices. These entities provide step-by-step assistance in managing the transformation process and support the efforts of improving the patient experience. For more information, or to find a Transformation Assistance Contractor, visit: https://www.health.ny.gov/technology/innovation_plan_initiative/ta_contact_info.htm.

Enhanced reimbursement opportunities: Practices that participate in NYS PCMH transformation may be eligible to receive supplemental payments through State programs such as the Medicaid PCMH Incentive Program. In addition, NYSDOH is engaged regionally with commercial payers to implement voluntary, multi-payer VBP arrangements to support practices that have not had these opportunities through previous transformation efforts. Many of these models and eligibility to participate will depend on practices achieving NYS PCMH recognition.

This all leads to lower health care costs, improved patient experience and better health outcomes.

As of 12/31/2018 1,515 primary care practices across NYS enrolled in the NYS PCMH program. Of those sites, 1,140 (75%) chose to work with a SIM-funded Transformation Agent contractor (representing 48% of the originally proposed 2,400 practices the agents estimated they would be able to assist over the life of their contracts). In total, 195 primary practices have achieved NYS PCMH recognition from NCQA.

The Statewide Steering Committee continues the work of Integrated Care Workgroup, providing oversight and support for New York's NYS PCMH model.

INTEGRATED CARE FOR ALL: NYS PCMH CAPABILITIES, GATES, AND MILESTONES	
PILLAR 2.2	Promote consistent standards and expectations for NYS PCMH capability on a spectrum of advancement to achieve fully integrated care.

NYS PCMH (described in Pillar 2.1) was developed to include concrete standards and expectations for progress through practice transformation. 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.

The NYS PCMH recognition program features six concepts that make up a medical home which help primary care practices to: help primary care practices in NYS: (1) improve patient-centered access and patient experience; (2) perform comprehensive health assessments to identify patient needs; (3) deliver better preventive care such as immunizations and cancer screenings; (4) prioritize comprehensive care management to keep chronic conditions under control; (5) coordinate with other clinicians involved in patient care and close referral loops to improve continuity and avoid gaps; and (6) identify patients who require recommended interventions and patients who need medication monitoring.

Practices engage in a series of activities to improve their capacity to address these critical areas. Criteria are the basis for these concepts. These activities are the "criteria" of the NYS PCMH model. Criteria were developed from evidence-based guidelines and best practices. Primary care practices must demonstrate satisfactory performance within criteria to earn NYS PCMH Recognition.

To earn NYS PCMH Recognition, a practice must demonstrate mastery of 52 "core criteria" which include 40 criteria which are common to NCQA's PCMH 2017, and 12 additional criteria that are NYS Specific. NYS adopted 12 additional core criteria which were identified as critical to achieving SHIP goals. These 12 additional Core Criteria, in addition to the 40 standard PCMH criteria, represent the fundamental building blocks in the areas of behavioral health integration, care coordination, Health IT capabilities, VBP arrangements, and Population Health in NYS. The NYS PCMH Standards and Guidelines[13] document details program requirements.

To achieve NYS PCMH recognition, primary care practices in NYS must enroll in the NYS PCMH program through the NCQA portal, Q-PASS. Primary care practices may choose to pursue recognition on their own, or with the assistance of a SIM-funded Practice Transformation contractor. Each practice is assigned an NCQA representative to assist the practice with educational resources and to help troubleshoot issues that may come up in the transformation process. After enrolling in Q-PASS, primary care practices must submit evidence (described in the Standards and Guidelines document) demonstrating mastery of each criterion. NCQA, in collaboration with NYSDOH, reviews the evidence submitted. Upon completion of the NYS PCMH criteria, practices will receive NYS PCMH recognition from NCQA.

[13] Available at: http://store.ncqa.org/index.php/catalogsearch/result/?q=NYS+PCMH+Standards+and+Guidelines

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 NYS PCMH 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 (PT TA) 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 specific competencies. In 2018, PT TA contractors transitioned to assisting practices achieve NYS PCMH recognition. PT TA contractors were already experienced in PCMH, allowing for a smooth transition. PT TA 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 NYS PCMH criteria and components using a questionnaire developed by HRI/NYSDOH and shared with funded contractors;
- support to enrolled primary care practices in building capabilities to reach NYS PCMH recognition; and
- submission of evidence and reports on practice achievement of NYS PCMH criteria to HRI/NYSDOH.

PT TA contracts were awarded regionally. A total of 15 contractors were awarded.

Information about PT TA entities is available here: https://www.health.ny.gov/technology/innovation_plan_initiative/ta_contact_info.htm.

INTEGRATED CARE FOR ALL: INDEPENDENT VALIDATION AGENT & TRACKING PROGRESS	
PILLAR 2.4	Deploy an NYS PCMH recognition process that builds on NCQA standards, or equivalent standards such as CPCi criteria.
ENABLER B.7	Enable the operation of the NYS PCMH model by providing support for NYS PCMH recognition as well as any new resources needed for progress tracking and evaluation.

In lieu of a specific contracted Independent Validation Agent, OQPS leveraged NCQA's 3-level oversight process to ensure that NYS PCMH practices and PT TAs continue to maintain compliance, accountability, and appropriate progress required to achieve and sustain recognition. NCQA, in collaboration with NYSDOH staff, review progress and material evidence submitted by NYS PCMH practices that partner with PT TAs through the cognition process. In addition to this qualitative surveillance, extensive efforts are made to prevent non-duplication of funding, through the Practice Transformation Tracking System (PTTS).

In 2018, the PTTS developed into a complex platform that mirrors data generated by NCQA's recognition system. NYS PCMH data is further monitored and analyzed to ensure that practices, PT TAs and NCQA, as vendors, continuously maintain a high level of accuracy in reporting requirements and transformation progress.

Following discussions with stakeholders and the Statewide Steering Committee about the sustainability of APC after SIM funding has ended, NYSDOH transitioned to NYS PCMH as the care delivery model for SIM. NYS PCMH is discussed further in Pillar 2.1.

Activities NCQA oversees and completes include: (1) conducting practice level eligibility, program requirements and evidence review; (2) conducting practice level qualitative reviews to ensure appropriate transformation is taking place; (3) proposing corrective action plans to remedy deficiencies in practice transformation activities; (4) providing monthly and ad hoc reports on 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 2018, OQPS, OHIP, and other stakeholders from NYSDOH continued to work together to develop innovative ideas to accelerate the adoption of VBP in NYS. A key focus of the past year has been on the *alignment* and *simplification* of VBP initiatives across NYS that span the public and private sectors. OHIP, OQPS, and other stakeholders recognize that identifying synchronicities between VBP initiatives creates a more solid foundation for future work and reduces burdens on providers.

NYS will continue to collaborate with public and private stakeholders, including CMMI and CMS, to create innovative care delivery models. Opportunities for providers to succeed in VBP arrangements will be expanded by: (1) aligning state-led value-based initiatives with federal measures and guidelines to reduce confusion and complexity; and (2) increasing the opportunities for providers to participate in Advanced Alternate Payment Models (Advanced APMs).

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 ongoing meetings to develop regional payment frameworks that operationalize the NYS advanced primary care model: NYS PCMH.

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 NYS PCMH and providing professional facilitation and convening services to ROMCs 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 2019.

In 2018, the Capital District/Hudson Valley ROMC launched a voluntary multi-payer model focused on small primary care practices. Four payers, including the CDPHP, MVP, Anthem Blue Cross Blue Shield, and United Healthcare's Empire Plan, committed to providing incentive payments to a set of practices in the region. The New York Metropolitan Areas ROMC designed a separate voluntary multi-payer model that launched 01/01/2019. Payers in the New York Metropolitan Areas including Anthem Blue Cross Blue Shield, United Healthcare, United Healthcare the Empire Plan, and Aetna, agreed to offer uniform incentive payments to a selected set of primary care practices in the region to encourage practice transformation and readiness for VBP contracting. The Finger Lakes ROMC continued to meet to identify a set a primary care practices that might benefit from a voluntary multi-payer model in the region. An RFP was issued to support the development of a ROMC in the Western Region of NYS. The Western ROMC is expected to launch in 2019.

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 (VBID); 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 (QARR) in 1994 and made the data available in a consumer tool in 1995.[14] In 2014, NYSDOH redesigned its Health Profiles[15] site. Health Profiles enables consumers to find and compare quality and safety data on New York's hospitals, nursing home, home care, adult care, and hospice facilities. Since 2015, NYSDOH has actively engaged in research on consumer transparency, conducting focus groups and research assessing available consumer information.[16] NYSDOH has worked with the New York Academy of Medicine (NYAM) 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. In 2018, NYAM conducted additional consumer focus groups on a subset of the 33 shoppable health care goods and services.

In 2018, the public-facing website for the APD, NYS Health Connector[17], was launched. Three data releases were accomplished during 2018, with four dashboards now available for public use. These four dashboards – Suicide and Self-Harm, Volume and Estimated Cost of Hospital Services, Emergency Department Visits in New York State, and New York State Flu Tracker – are powered by Tableau allowing for customization and visualization.

DOH also completed prototypes with Honest Health on a price transparency tool and a chat bot. The NYAM will test the prototypes with consumers in 2019. The price and quality transparency tool align the best practices for user interfaces with the expected data from the APD, to demonstrate what will be available to consumers. The chat bot prototype uses neural net technology to learn and answer a consumer's question regarding finding online resources for purchasing health insurance, finding prescription pricing, finding or researching a doctor or a hospital.

[14] eQARR is an interactive online tool that allows consumers to view quality performance results for health plans in New York State.
[15] Health Profiles makes it easy to find quality and safety information.
[16] Final reports for consumer research and focus groups can be found here: https://www.health.ny.gov/technology/all_payer_database/.
[17] NYS Health Connector website: https://nyshc.health.ny.gov/web/nyapd/home

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 (NYeC), 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 Regional Health Information Organizations (RHIO), 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 an 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.

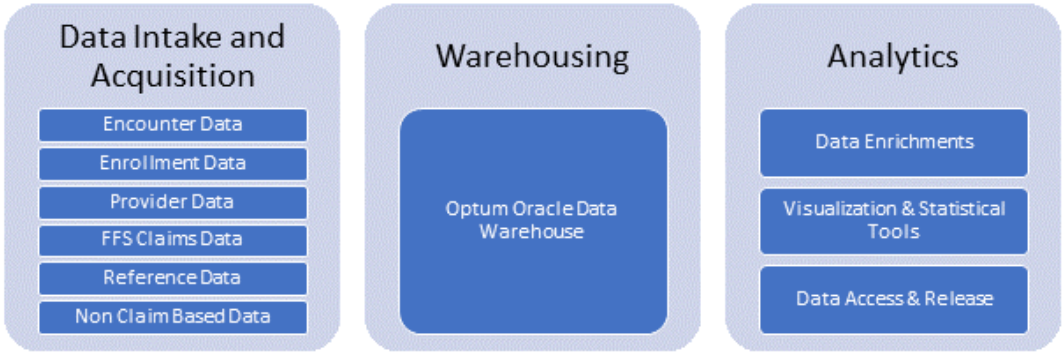
NYSDOH subsequently completed landscape, marketplace, and feasibility analyses to assess the utility of the planned patient portal. Through these efforts it was determined that functionalities planned for the portal were not viable. There remains a need for consumer access, but the portal developed was 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 Electronic Health Records (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 2, below.

FIGURE 2: 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 3 below

FIGURE 3: ALL PAYER DATABASE DEVELOPMENT TIMELINE 2019

Month(s)	Release/Product Deployment
January – March	**Original Data Source Submitter (OSDS) Project** Development Phase
April – June	**NYS Health Connector Release 4 Dashboards** **Original Data Source Submitter (OSDS) Project** Development & Build Phases
July – September	**NYS Health Connector Release 5 Dashboards** **Original Data Source Submitter (OSDS) Project** Development & Build Phases **Warehouse and Analytic Solution Phase 3 Deployment** Medicare data added: Consolidated Member, Provider, and Issuer Plan Areas Master Patient and Provider Indexes **APD Annual Stakeholder Meeting**
October – December	**NYS Health Connector Release 6 Dashboards** **Original Data Source Submitter (OSDS) Project** Pre-Testing Phase

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.

Figure 4 provides a snapshot of APD releases in 2018.

FIGURE 4: 2018 APD RELEASES

Month	Release/Product Deployment
December 2018	**NYS Health Connector Release 3 Dashboards** New York State Flu Tracker
October 2018	**Warehouse and Analytic Solution Phase 2 Deployment** Consolidated Claims Area
September 2018	**NYS Health Connector Release 2 Dashboards** Suicide and Self Harm Emergency Department Preventable Visits **Warehouse and Analytic Solution Phase 2 Deployment** Consolidated Member, Provider, and Issuer Plan Areas Master Patient and Provider Indexes
May 2018	**NYS Health Connector Release 1 Dashboards (Launch)** Suicides in New York Volume and Estimated Cost of Hospital Services Emergency Department Visits in New York State
March 2018	**SPARCS Intake Solution (Launch)** **Warehouse and Analytic Solution Phase 1 Deployment** SPARCS Area Vital Statistics Mortality Area Tableau Analytic Reports and Dashboards

In 2018, the APD launched the hospital discharge data system (SPARCS) intake solution, deployed three phases of the APD, including: Phase 1: SPARCS and Vital Statistics Mortality release, Phase 2: Consolidated Member, Provider, Issuer/Plan data and Phase 3: Consolidated Claim data; Internal Analytic Portal with Tableau Dashboards, and an external public site powered by Tableau called the NYS Health Connector.

The annual stakeholder meeting was held on May 16, 2018 at the Empire State Plaza with over 350 individuals from more than 100 different organizations and state entities in attendance.

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

Value-based insurance design (VBID) aims to promote patients' use of high-value care options by changing the cost-sharing for different care options. VBID attempts to align patients' out-of-pocket costs, such as copayments and premiums, with the long-term value of the health services. VBID seeks to reduce barriers to high-value treatments (through lower costs to patients) and discourage low-value treatments (through higher costs).

In previous years, the Department of Health explored adopting a VBID benefit for state employees with the assistance of the Department of Civil Service. A contractor, the Value-Based Insurance Design Center at the University of Michigan was retained in an advisory capacity to facilitate these discussions. However, it was determined that VBID is not a feasible option for the New York State Health Insurance Program for State and Local Government at this time. No further efforts concerning VBID were pursued during the 2018 calendar 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 VBP models. The State encourages broad use of VBID 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 (FFS) payment models do little to reward quality or efficiency. On the contrary, they reward providers simply for the volume of services provided, and in fact may inherently disadvantage those providers who deliver higher quality care with lower frequency of complications. It is also clear that current FFS reimbursement is not available for most of the interventions required in NYS PCMH 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 health care dollars go to overtreatment, inefficiency, and fragmented care delivery.

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

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

.

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 VBP 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 VBP contracts are based.

In 2018, the Capital District/Hudson Valley ROMC and the NYC ROMC finalized the details of their voluntary multi-payer primary care models specific to their regions. Payers met frequently during “payer only” meetings to discuss the design, development, and implementation of the models under consideration. While each ROMC followed a similar process to develop the model, the details of each model are tailored to the specific needs of the ROMC regions. Both the Capital District/Hudson Valley and NYC ROMC:

- Provided data to identify a cohort of “target practices” that would be eligible for enhanced payments from the payers.
- Identified the lines of business (e.g. commercial, Medicaid, Medicare) eligible for enhanced payments from the payers.
- Agreed on a common set of quality measures from the Primary Care Scorecard to use to assess model performance.
- Committed to providing enhanced payments to target practices that achieved NYS PCMH recognition
- Developed a strategy for recruiting target practices using SIM-funded Transformation Agents.

The Capital District/Hudson Valley model was launched in 2018, and the NYC ROMC model is scheduled to launch 01/01/2019. The Finger Lakes ROMC continues to discuss the design, development, and implementation of their region-specific model. It is expected that the Western ROMC will begin a similar process in 2019.

PAY FOR VALUE NOT VOLUME: MEDICAID STATE PLAN AMENDMENT	
PILLAR 4.2	Establish a flexible framework for VBP under NYS PCMH
PILLAR 4.3	Adopt value-based payment for advanced primary care 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 VBP 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 advanced primary care on health care quality, outcomes, and cost. The SPA was originally submitted on March 31, 2017. Due to feedback from CMS, the original SPA was resubmitted as four separate amendments specific physicians and nurse practitioners, hospital-based clinics, freestanding clinics, and Federally Qualified Health Centers. SPA 17-24-A; 17-24-B; 17-24-C; and 17-24-D were approved by CMS on June 14, 2018.

In addition to the APC practices that are eligible for incentive payments through the SPA, NYS PCMH recognized practices are also eligible for incentive payments.

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 NYS PCMH more universally accessible to providers

CMS oversees 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 VBP for NYS PCMH 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. NYS PCMH was designed to align across the numerous, diverse, and at times confusing, landscape of initiatives to increase VBP 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 VBP to NYS PCMH practices. Often these efforts occur through public and private communications to CMS and CMMI, as well as efforts to align and simplify statewide VBP initiatives such as DSRIP or SIM such that burdens on patients, providers, and payers and reduced.

In 2018, NYSDOH continued to engage CMS and CMMI in efforts to develop an advanced APM appropriate for NYS that would build on both SIM and DSRIP. Through SIM, NYSDOH met regularly with CMMI officials to request data and other resources to support the development of an advanced APM. NYSDOH has also been in regular communications with the advanced APM team at CMMI to assist with strategic planning around the development of such a model. Within NYSDOH, OHIP and OQPS met regularly to discuss and align activity around the development of a state-led advanced APM that would build on both DSRIP and SIM infrastructure. NYSDOH will continue to advocate to make VBP for NYS PCMH 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 VBP 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 VBP participation among insurers. For example, DFS developed a model to credit insurers VBP 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 VBP business across private payers. DFS and NYSDOH collaborated to measure the overall extent of VBP contracting across NYS, both in terms of percentage of members and percentage of participating providers covered under VBP contracts. The first survey resulted in the publication of the Catalyst for Payment Reform scorecard.

DFS also issues guidelines to support VBP 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 VBP. 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 SHIP. NYS PCMH 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 NYS PCMH practices;
- build and maintain community resource registries and ensure that NYS PCMH 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.

New York's six Linking Interventions for Total Population Health (LIFT) projects align health care system improvement activities with community-based efforts to target social determinants of health and improve the health of communities. These projects cover 18 counties and bring together key sectors from the community to collectively advance one health priority from New York's Prevention Agenda.

As clinical service delivery is already a major focus of the SIM project, the focus of LIFT is to leverage and connect existing clinical services and activities with community, policy and environmental interventions.

LIFT activities align locally with work being conducted by other initiatives in New York State (e.g., SIM, DSRIP, Prevention Agenda, Population Health Improvement Programs (PHIP), and other state and Center for Disease Control and Prevention-funded initiatives). Communities were asked to focus on one of five issues related to the Prevent Chronic Disease priority area of the New York State Prevention Agenda 2013-18. Five projects chose Prevent and Control Obesity and Diabetes and one project chose Prevent Cardiovascular Disease and Control High Blood Pressure.

Awardees developed a portfolio of interventions across three categories or "buckets"

1. Traditional Clinical Prevention (10% of effort)
2. Innovative Clinical Prevention (30% of effort)
3. Total Population or Community-Wide Prevention (60% of effort)

The efforts of the LIFT projects focus on reducing health inequities and on the needs of communities with populations most at risk for poor health outcomes.

TABLE 5: 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
Population Health Collaborative (formerly P2)	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

Each LIFT project has been designed by the awardee to meet the needs of their community, so each project's activities are different. However, the broader interventions that encompass the activities are described below:

Bucket 1: Traditional Clinical Prevention

- Health system changes to promote participation in the Diabetes Prevention Program (DPP) – Population Health Collaborative, HealthlinkNY, S2AY, Fort Drum, University of Rochester

- Health system changes to support Diabetes Self-Management (DSM) – Population Health Collaborative

- Expand Public Health Detailing (PHD) for hypertension – Fund for Public Health

Bucket 2: Innovative Clinical Prevention

- Establishing and promoting Clinical Community Linkages to promote participation in DPP and Lifestyle Change Programs – Population Health Collaborative, HealthlinkNY S2AY, Fort Drum, University of Rochester

- Establishing and promoting Clinical Community Linkages to promote participation in disease self-management programs – Population Health Collaborative

- Using pharmacists to promote medication adherence for hypertension – Fund for Public Health

Bucket 3: Total Population or Community-wide Prevention

Nutrition/Healthy Eating

- Media/Social Marketing (examples include development of website around decreased consumption of sugar and development of social media messaging around increased consumption of fresh produce) – Population Health Collaborative

- Promote policy, system and environmental (PSE) change to increase access to healthier foods & breastfeeding (examples include training and placing certified lactation consultants in high needs areas, working with community-based organizations to adopt breastfeeding friendly spaces) – Population Health Collaborative, S2AY, HealthlinkNY, Fund for Public Health

- Support existing food programs (examples include promoting summer feeding programs and farmer's markets) – S2AY

Site Specific Wellness Policies

- Promote worksite wellness through policies and programs (such as worksite wellness trainings and conducting National Diabetes Prevention programs at worksites) – S2AY

- Support the development, adoption and implementation of school local wellness policies – Fort Drum

Physical Activity

- Media/Social Marketing (examples include social marketing around walking and the creation of walking clubs) – Population Health Collaborative

- Conduct environmental assessments and develop community resources (such as the development of maps and lists of sites for indoor and outdoor physical activity) – University of Rochester, Fund for Public Health

- Use PSE to encourage physical activity, including Complete Streets – Fort Drum, Population Health Collaborative, HealthlinkNY, Fund for Public Health

PROMOTE POPULATION HEALTH-CONNECT PRIMARY CARE TO POPULATION HEALTH IMPROVEMENT: 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 NYS PCMH practices
PILLAR 5.3	Build and maintain community resource registries and ensure that NYS PCMH 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 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 Prevention Agenda 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/.

The Prevention Agenda is in the process of being updated for the next five years from 2019-2024. The Prevention Agenda continues to be developed and implemented at the state and local levels with a broad mix of organizations and establishes goals for five priority areas and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities. The Prevention Agenda also identifies interventions shown to be effective to reach each goal and serves as the foundation for the Department's population health activities.

Efforts are ongoing to integrate the Prevention Agenda into NY's health systems transformation efforts and include:

- NYSDOH SIM held a training for Practice transformation agents who help practices become recognized as NYS PCMH providers. The training included presentations on how to address social determinants of health and best practices for making community-clinical linkages.

- NYSDOH OPH staff continue conversations with the NYSDOH Medical Director who is a member of the NCQA steering committee. The goal is to advocate for the inclusion of population health measures in the NYS PCMH model so that elective measures would become core or be required at one year check in for new NYS PCMH practices.

NYS OPH will continue to identify opportunities to further integrate population health activities into the NYS SIM Model.

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

PHIP 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 SHIP and serve as resources to DSRIP PPS.

In 2018, PHIPs continued their work engaging stakeholders in collaborative strategic planning, performing data analytics that inform regional activities, and communicating progress and sharing 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 NYS PCMH and its expected impact on regional activities. PHIPs also continued 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 electronic health records (EHR), including the participation in Meaningful Use by eligible providers and hospitals;

- promote provider participation in bidirectional health information exchange (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 NYS PCMH model by providing support for NYS PCMH 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 SHIP's 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. As of 2015, 67% of primary care providers had EHRs, 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 NYS PCMH 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 NYS PCMH-enrolled primary care practices when connecting to their local QE. The Initiative became available for NYS PCMH-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 NYeC, 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 RHIO, is a regional network where electronic health information is stored and shared. There are seven 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 seven 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 100% of hospitals in New York State, over 100,000 medical providers, and represents millions of people who live in or receive care in New York. In 2018, OQPS continued to work to plan and develop capabilities for alignment of data with 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 2018 program year. In 2018, Health Data NY saw 157,480 unique users and 13,160 unique users to the NYS Health Connector in 10 months.

PERFORMANCE MEASUREMENT AND EVALUATION: PRIMARY CARE SCORECARD	
ENABLER C.1	Primary Care Scorecard/HIT Enabled QM

As part of its initiative to integrate service delivery and reimbursement in NYS by implementing NYS PCMH, NYSDOH has developed, tested, and disseminated a common set of core quality measures relevant to NYS PCMH participating payers and practices. These core measures reported as part of the Primary Care 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 (TIN), 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 Primary Care core measure set consists of 28 nationally endorsed administrative and hybrid measures, including one survey measure. All measures are described in Figure 5. Measures included in the Scorecard Version 1 (2017) and Version 2 (2018) 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 and Version 2 of the Primary Care Scorecard in late 2017 and 2018 respectively. 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. Version 2 added three additional utilization measures including inpatient, emergency department, and outpatient visits.

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 Primary Care 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 5: NEW YORK STATE 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	Anti-depressant 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 IV: 2018 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. Implementation of SIM funded programs and initiative occurred in 2018

Table 6 provides an overview of the expenditures for the 2018 SIM program year.

TABLE 6: OVERVIEW OF 2018 STATE INNOVATION MODEL EXPENDITURES

Category	SIM 2018 Expenditures 1/1/2018-12/31/2018
Salaries	$1,431,616.89
Fringe Benefits	$514,364.61
Equipment	$0.00
Supplies	$219,326.47
Travel	$28,087.98
Services	$14,694.92
Contractors	$19,188,015.64
Miscellaneous	$0
Indirect Costs	$433,223.39
TOTAL	**$21,829,329.90**

SIM Expenditures for 2018 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 2018 program year. Table 7, below, provides a detailed breakdown of contract expenditures by SIM driver.

TABLE 7: STATE INNOVATION MODEL EXPENDITURES BY DRIVER

Category	Driver Expenditures 01/01/2018-12/31/2018
Global Contracts	$2,396,087.00
Driver I- Access to Care Contracts	$589,834.00
Driver II- Integrated Care	$13,328,104.95
Driver III-Transparency, Evaluation and Health Information Technology (HIT) Contracts	$2,181,252.49
Driver IV-Population Health Contracts	$426,682.46
Driver V-Workforce Contracts	$266,054.74
TOTAL	**$19,188,015.64**

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

ACRONYM	DEFINITION
ACGME	Accreditation Council on Graduate Medical Education
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	Division of the Budget
DSRIP	Delivery System Reform Incentive Payment Program
FFS	Fee for Service
GME	Graduate Medical Education
HEDIS	Healthcare Effectiveness Data and Information Set
EHR	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
LIFT	Linking Interventions for Total Population Health
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit Incentive Payment System
NCQA	National Committee for Quality Assurance
NYAM	New York Academy of Medicine
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	Performing Provider Systems
Project ECHO®	Project Extension for Community Healthcare Outcomes
PSE	Policy, System, and Environmental
PT TA	Practice Transformation Technical Assistance
PTTS	Practice Transformation Tracking System
QARR	Quality Assurance Reporting Requirements
QE	Qualified Entity
QM	Quality Measurement
Q-PASS	Quality Performance Assessment Support System
RFA	Request for Applications
RFI	Request for Information
RFP	Request for Proposals
RHIO	Regional Health Information Organizations
ROMC	Regional Oversight Management Committee
SED	State Education Department
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
VBID	Value-Based Insurance Design
VBP	Value-Based Payments

This page intentionally left blank