



Primary Care Expansion

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

Answer #1: New York State has the largest Medicaid program in the country with 26 percent of the State's population enrolled in Medicaid. At more than \$50 billion a year, New York spends more than twice the national average on Medicaid on a per capita basis, and spending per enrollee is the second-highest in the nation. Moreover, increased Medicaid spending has not resulted in high quality of care. The state ranks 18^h out of all states for overall health system quality and ranks 50th among all states for avoidable hospital use and costs. Hospital readmissions are a particularly costly problem for New York. A report issued by the New York State Health Foundation found hospital readmissions cost New York \$3.7 billion per year, with nearly one in seven initial hospital stays resulting in a readmission.

As a result of the Affordable Care Act (ACA) and the initiatives of the Medicaid Redesign Team (MRT), New York State's health care system has made significant strides toward the Triple Aim. New York's health care delivery system and its financing are radically changing from the system of just a few years ago. The driving force behind the MRT's efforts is a growing Medicaid program in the state that has largely overinvested in expensive institutional care and underinvested in less costly primary and preventive care. A principal strategy of the MRT has been to promote integrated, coordinated systems of care with a strong primary care foundation. The MRT 1115 Waiver Amendment presents a significant opportunity to accelerate progress toward this important objective.

Question #2: How will this program help achieve the Triple Aim in New York?

Answer #2: Increasing access to high quality primary care services is essential in developing a community-based health care infrastructure which will ensure New York achieves the Triple Aim. There is broad consensus that to achieve the Triple Aim, high-quality, and accessible primary care must be available to all residents. A principal strategy of the MRT has been to invest in integrated systems of care with a strong primary care foundation. The MRT has begun to strengthen and transform the health care safety net and taken a more community-based approach to health care by addressing health disparities as well as the social determinants of health – including socioeconomic status, education, food, and shelter.



Primary Care Expansion (continued)

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples.

Answer #3: The goal is to transform New York State's health care delivery system into one that is completely integrated and provides access and coordinated care to every New Yorker. We need to shift from an emphasis on fragmented institutional care to an integrated system that has a foundation of primary and preventive care. To accomplish this goal, New York will not only invest in the preservation and expansion of primary care services but integrate primary care into the overall health care system.

There is a substantial need for capital to expand primary care capacity in order to provide care for more people as newly insured individuals come into the marketplace. A key focus in restructuring will be building sustainable primary care capacity where it does not currently exist. It is also important to provide technical assistance to existing primary care providers to ensure they have needed financial and business planning skills to increase primary care capacity in the new health system environment. New York plans to locate services in settings that are most accessible to the populations served. For example, co-locating primary care services in Emergency Departments, supportive housing or mental health programs increases the likelihood that they will be utilized. Telemedicine also offers the possibility of providing needed services in underserved areas of the state.

There is also additional need for capital investment to build the technological infrastructure that networks will need to operate effectively. New technologies offer opportunities to improve the quality of the care provided, particularly with respect to care transitions, team based care and integration of services for complex populations. The increased connectivity available through data and information sharing such as Electronic Health Records offer tremendous opportunities to manage the continuum of a patient's care – from prevention to treatment, including self-management.

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

Answer #4: The Department of Health will award contracts through a competitive request for grant applications process to qualified organizations that meet the technical specifications as outlined in the application.



Primary Care Expansion (continued)

Each applicant must fulfill numerous requirements to receive funding including describing the background, experience, and structure that qualify them as bidders, and if applicable, its subcontractor(s), to undertake the functions and activities required.

Bidders must be able to provide evidence of their financial ability to perform the terms and conditions of the contract. All bidders must detail their proposed approach and provide a completed work plan outlining how they will address the program requirements and detail when activities will be completed. Successful applicants will be required to submit quarterly reports that describe grant activities and evidence that they are meeting all requirements at specified timeframes. Providers that fail to meet agreed upon deliverables will jeopardize future funding as the State can exercise its option to cancel the contract due to unsatisfactory performance.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

Answer #5: As stated above, the Department of Health will award contracts through a competitive request for grant applications process to qualified organizations that meet the technical specifications as outlined in the application. Each applicant must fulfill numerous requirements to receive funding including describing the background, experience, and structure that qualify them as bidders, and if applicable, its subcontractor(s), to undertake the functions and activities required. Bidders must be able to provide evidence of their financial ability to perform the terms and conditions of the contract. Also, all bidders must detail their proposed approach and provide a completed work plan outlining how they will address all the program requirements. The contracts will be for a maximum contract period of five years, subject to the sole option of the State and satisfactory performance and availability of funds. The exception to this process is the proposed Revolving Capital Fund. This revolving fund may be managed by an external private partner. The terms and conditions of loans and repayments will be delineated.



Primary Care Expansion (continued)

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

A major challenge will be providing high-quality primary care to the surge of newly insured individuals thanks to the ACA. Already an estimated 2.3 million New Yorkers are “underserved” for primary care. State and federal funds have been expended to help address this challenge. However, funding gaps still exist. For example, the Regional Extension Centers (RECs) program has been successful at increasing the numbers of providers adopting EHRs and attaining NCQA PPC-PCMH Level 1, but will need additional resources to reach additional providers, including sole and group physician practices. Also, the state has invested significant state and federal dollars to achieve 2008 NCQA accreditation for patient-centered medical homes, but state funds are limited, and additional federal funds needed, to help many providers achieve the 2011 standards, especially smaller and rural providers. Finally, the waiver funds requested for the Revolving Capital Fund will be used to leverage private investment and “seed” a fund that would be self-sustaining after the 5-year waiver period, as access to capital would revolve as the existing group of borrowers pay back their loans and the funds redeployed to build more primary care capacity on an ongoing basis.



Health Home Development Fund

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

New York's Health Home program has tremendous promise to meaningfully connect disparate "siloed" health care services and keep our sickest Medicaid members out of the inpatient hospital and the emergency department. Currently, there are 805,000 members with behavioral health and/or chronic medical conditions that are eligible to enroll in New York's first wave of the Health Home initiative. Although we are focusing our enrollment on the highest risk subset of this population, only approximately 12,000 of these members have been enrolled in Health Homes thus far in phase one of the State's three phase statewide roll out. Although enrollment is currently increasing sharply as contracts and other mandated patient tracking capabilities come on line, additional resources from the waiver will assist the State in maximizing the outreach capability and the care management effectiveness of the program. The Health Home Development Fund will address the following problems that, left unaddressed, will continue to contribute to reduced enrollment and limits on care management effectiveness.

- **Member Engagement** - Health Home providers are being challenged to locate, engage and retain eligible members in care management. Despite the provision of a case finding fee, significant additional resources are needed to find and engage members. Additionally, New York State has been unable to initiate a public awareness and education campaign and as a result, some confusion exists about Health Homes especially outside of the health care service sector.
- **Workforce Training and Retraining** – Although our existing care management programs provide an excellent base of staff to launch the Health Home program, New York State does not have an adequately prepared workforce to fully meet all the potential care management needs generated by the Health Home program. Resources are lacking to properly train and retrain care management workers.
- **Clinical Connectivity** – Although lower tech and less efficient work-arounds are being built, Health Homes currently lack the full infrastructure to share the data that is necessary to provide comprehensive care management. Funding is needed to fill critical gaps such as shared care management records and multi-party consent. Additionally, HIT and HIE resources have not been evenly distributed across the New York State health care and behavioral health care delivery system, and additional funding is needed to build connectivity for mental health, substance abuse and other critical community providers.



Health Home Development Fund (continued)

- **Joint Governance Support** - Providers are not fully prepared with the resources required to actuate the new governance models required to most effectively form and operate Health Home care management entities. New York requires Health Homes to contractually or organizationally include a wide range of providers including hospitals, community-based health and behavioral health providers, and social services providers including housing. These promising relationships will be tremendously effective clinically but new resources are necessary to properly bring together these entities in effective health home governance superstructures.

Question #2: How will this program help achieve the Triple Aim in New York?

The Health Home Development Fund will enable New York State to address the problems noted in question #1 above and facilitate enrollment of the targeted high cost high need populations into Health Homes. Health Homes by their very nature are designed to achieve the Triple Aim of improving the experience of care, the health of populations, and reducing the per capita costs. They have been conceived and designed in NYS using care management that is embedded in an integrated network of physical, behavioral, social and community health providers.

The ability of members to move seamlessly through a coordinated network of appropriate social, behavioral and medical providers will improve the experience of care by reducing the fragmented and uncoordinated care that has become all too common. This fragmentation leads to poor outcomes, with some individuals receiving too much of the wrong type of care (ER visits, multiple medications) and some receiving insufficient or inadequate care. Costs will be reduced through better outcomes and through efficiencies in care delivery.

To further assure Triple Aim success, the program utilizes a both a clinical risk group model and a predictive model to better guarantee that the highest risk and highest cost members get care management first and that their care management resources are higher. In addition to the clinical risk and predictive models, a loyalty model also helps to assure members are meaningfully connected to existing providers when making Health Home assignments to leverage existing positive clinical relationships.

Our larger waiver document includes examples from the literature of the promise of face to face care management in improving health outcomes and reducing cost. We also have been following closely recent evidence which suggests that less intensive telephonic and “lower touch” chronic disease specific interventions are less efficacious both from a quality improvement and cost reduction perspective.



Health Home Development Fund (continued)

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

Health Homes will be a robust, fully functioning and permanent part of the State's efforts to coordinate care for high need and high cost populations. When Health Homes are fully implemented, members will be carefully targeted for appropriate enrollment in Health Homes (when needed) and care management intensity will be indexed based on each member's current need. Health Homes will be a known and understandable model of care coordination in each community of NYS; and health homes will be a critical part of the fabric of the health care delivery system in New York State. When health homes are fully implemented, all needed providers will have real time access to members' medical record, claim information, care management record, clinical progress notes and other quality information about the patient. Further, real time alerts will be activated for trigger events (crisis, admission, discharge etc.) to the care manager and all needed clinicians. A portal will be developed to keep clinicians, care managers, patients and their families informed about progress in care and care management. A health home provider quality profile will be built into this portal with a dashboard that will allow members and payers to pick the highest quality Health Homes against standardized measures of success. A learning collaborative will be established which will allow lower performing Health Homes to learn from the higher performing programs.

Due to robust training capabilities, a highly qualified and motivated group of care managers will be working and collaborating in this important work in all areas of the state. Health Homes will be distributing gain sharing dollars to downstream partners that are all connected with sound joint governance models that are pivoting the focus from fee for service volume to receiving gain sharing revenue as member quality improves and as avoidable ED and Inpatient events are reduced through collaborative action around crisis response, admission diversion and more appropriate and better resourced discharge planning. Health Homes will refocus New York's health care delivery system to better addressing the complex needs of higher cost patients by fully structuring care management and service provision around improving health outcomes and incentivizing quality care.

This future will also include empowered and well trained care managers who can obtain priority access to primary care and housing for the State's most vulnerable populations. Additionally, it is expected that the future will also include empowered, health literate members who will understand their health care needs, have an established primary care physician, and will get their diverse and complicated needs met through much more carefully planned and delivered services.



Health Home Development Fund (continued)

The vision of health care in New York State is best described in the following chart developed by one of our Health Homes:

TODAY'S CARE	HEALTH HOME CARE
My patients are those who make appointments to see me	Our patients are those who are registered in our health home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	A multidisciplinary team works at the top of our licenses to serve patients



Health Home Development Fund (continued)

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

Funding for the development of Health Homes will include mandatory milestone performance measures to ensure that funded activities result in delivery of all funded components, increased enrollment, program awareness, clinical connectivity where it is currently lacking, trained care managers and the full establishment of joint governance models. Funding will be time limited and contingent upon the attainment of key measurable metrics and milestones.

Additionally, Health Homes that fail to engage the appropriate numbers of members in care management or that fail to appropriately report process and outcome data as required will no longer receive referrals and may be considered for termination of their Health Home status. Engagement and reporting are basic functions of the Health Home and Health Homes that cannot perform these functions cannot continue with their designation.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

The Health Home Development Fund will be funded with targeted dollars allocated through a competitive procurement process. Funding will be made available through specific funding availability solicitations with targeted purposes. Funding will be provided in phases and based on the achievement of specific measurable goals. For example, for member engagement and public education, the state would solicit through a procurement process, the development a public awareness and education campaign. The solicitation will contain start up funding, with specific requirements for deliverables. Additional payments will be made based on the attainment of these deliverables. Likewise, start up funds with specific benchmarks to develop clinical connectivity would be provided and additional funds will be contingent upon the delivery sequenced milestones that lead to the attainment of specific goals such as the attainment of a certain number of "connected" substance abuse and mental health providers.

The Health Home Development Fund will be used to focus waiver resources on tangible and time limited Health Home implementation barriers to support Health Homes until they can be self-sufficient and rely exclusively on current care management fees and shared savings incentives.



Health Home Development Fund (continued)

Waiver funds will be used on a one time basis to build the necessary infrastructure to address implementation challenges in four distinct areas: Member Engagement, Workforce Training and Retraining, Clinical Connectivity, and Joint Governance Support. Additionally, Health Home development funds will not duplicate funds made available through other waiver sources such as primary care expansion. Efforts on these separate proposals will be synchronized prior to issuing the funding availability solicitation.

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

Health Homes are funded through a *Per Member Per Month* (PMPM) payment for care management services, which will flow through lead Health Homes/Care Management agencies to network partners. While the PMPM rates include a small amount for administrative services, the primary purpose of the rate is to support care management and supportive services.

While there has been significant progress in the establishment of Health Homes and we are certain we can meet current state and federal requirements, there are still some fundamental infrastructure issues that need to be addressed to fully optimize Health Homes for which funding was not currently available, and these infrastructure issues will present a barrier to fully implementing Health Homes across the State. While solutions could be fashioned at the community level to address these issues, these "work arounds" and other patchwork solutions would not provide the most effective, efficient and statewide solution and would hamper the Health Homes' ability to truly integrate care and devote the PMPM to member services. New York State has already invested heavily in IT infrastructure, for example, that has the capacity for a state-wide interconnected healthcare network. However, state funding and even federal funding has focused primarily on the larger providers in the acute care industry, leaving a number of other health care and community providers without sourcing for the initial heavy lift of converting to an electronic health record.

While Health Homes are doing their best to provide needed community outreach during member engagement, the Health Homes have noted to the State that community knowledge of these new care management programs is very limited. Buzzwords like "health home" at the healthcare service level do not always resonate at shelters and other places where members must be engaged. Similar to the way in which the State transformed the culture around smoking behaviors, we need to transform the culture around healthcare access, use and care management. Resources for this community education in multiple languages and sensitive to health literacy issues are not readily available. The Health Home Development fund would support these essential educational materials.



New Care Models

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer, please describe the "current state" the program will attempt to transform/improve.

The Commonwealth State Report card shows that NYS currently ranks 50th in avoidable hospital use and cost. Resolution of a problem of this magnitude requires a multi-faceted approach that includes leveraging existing federal incentive programs and challenging and engaging those working in the health care system in communities throughout the State to develop new models of care that align financial incentives with improved health outcomes.

Core problems in the current health care delivery system include:

- A lack of infrastructure to provide the full array of services needed by people with multiple chronic health conditions. The current health care delivery system is better equipped to manage acute episodes, however the population needs of, for example, aging baby boomers, or the chronic care needs brought about by the obesity epidemic, are accompanied by a different set of challenges.
- Health care delivery is a disorganized/fragmented system. Health care is delivered through a series of referrals/hand-offs by disconnected hospitals, clinics, physicians, and other practitioners. This fragmentation puts patients at risk. Practitioners in various facilities may lack complete information about a patient's health condition, other services they may be receiving, or medication provided by other health care providers. The more vulnerable and complex the patient, the greater the risk.
- Current financial incentives in the system are structured around the provision of additional services, with only small portion of State funding set aside to promote quality.
- There is a lack of comprehensive health care data accessible in a timely manner by all health care providers engaged with a patient.
- The state currently lacks a pool of resources to test new ideas and bring them to scale without fully embedding them into mainstream payment system prior to testing.

Improving the health care infrastructure to better manage and prevent chronic conditions, integrating health care delivery systems, and leveraging technology and communication systems to effect accessible health care data across providers will address these core problems in health care delivery. This program outlines several potential ideas that were received during the stakeholder outreach/engagement process the State engaged in to develop its application. We anticipate additional ideas will emerge through the competitive bid process that will both appropriately challenge and support the health care community.



New Care Models (continued)

Question #2: How will this program help achieve the Triple Aim in New York?

The Triple Aim goals of better care for individuals, better health for populations, and reduced per-capita costs are well served by the New Care Models initiative, which will fund projects that meet rigorous criteria designed around the Triple Aim through a competitive bid process. Acceptable proposals will address fundamental Triple Aim goals and will include a comprehensive description of the proposed new model of care, evidence upon which the proposed model is based, the problem(s) the new care model will address, including any relevant data, the population(s) targeted by the care model and their characteristics, the health care partners that will participate in the program, how the new model will impact the Triple Aim goals, the projected return on investment, and the performance measures against which the model will be evaluated.

In particular, this program will help achieve the Triple Aim in New York by *engaging communities* in the process of reforming the health care delivery system. Support in the form of funding opportunities (planning and operational dollars) and incentives (quality pool) of initiatives conceived and carried out with community involvement is fundamental to achieving true health care reform that addresses the needs of diverse communities across the State. This “bottom up” approach acknowledges that the health care community itself must embrace and participate in changing the health care delivery system to meet the health care challenges facing the State.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

New York’s request for proposals under New Care Models will solicit projects that tackle both cost and quality issues affecting New York’s Medicaid program, with particular attention to projects with promise for improving health care quality and results for the State’s most vulnerable patients.



New Care Models (continued)

In the post-waiver period, New Yorkers will receive health care that meets their needs and is based on scientific evidence. Health care delivery will be characterized by:

- Improved quality;
- Care processes based on evidence/best practices;
- Effective care management teams;
- Efficient information sharing;
- Payments in alignment with quality;
- Care that is coordinated across patient conditions, services, settings;
- Quality of care that is consistent across patient conditions, services, settings;
- Established outcome measures that measure improvement and ensure accountability;
- Opportunities for providers to share in savings that accrue from their direct efforts, when those efforts improve patient care, population health and effect cost savings.

Many of the models funded through this program will be replicated all over the country. New York is fully prepared to be the health care reform laboratory for the nation.

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

Each project that is funded must include the performance measures against which the model will be evaluated, both in real time and at the conclusion of the five-year waiver period.

Quality measures will include metrics that evaluate outcomes and quality of care. These include, but are not limited to, potentially preventable events such as avoidable emergency room visits, hospitalizations, preventable hospital readmissions and preventable ER visits, and patient satisfaction measures that assess patient safety indicators, care coordination, and getting necessary care quickly.

Metrics would be tailored to suit the specific projects awarded funding under the New Care Models initiative, and specific quality improvement targets for each program will be carefully monitored by the State to determine whether the quality improvement targets are met or course corrections are required. In addition, the time line for planning grants for New Care Models builds in decision points (formal program review) at years four and five. Those models not meeting Medicaid program goals would be phased out and enrollees transitioned to other effective care models/services.



New Care Models (continued)

In summary, programs not meeting targets would not participate in the quality pool, would be notified and receive technical assistance to facilitate meeting targets, and would be discontinued by the close of year five if they failed to perform as expected.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

Initial projects will be funded with targeted dollars allocated through a competitive procurement process. The "flow" of funds to approved projects will depend in part on the awarded project. Planning dollars and operational dollars would only be provided to awarded projects through the competitive process; quality pool funds would only flow to selected projects that also exceed outcome benchmarks. Funding would be provided in phases based on the achievement of specified and measurable benchmarks and program parameters. Initial program implementation/planning would be funded in Year 1, full program implementation funding in Years 2 and 3, with quality pool payments made to programs exceeding performance/outcome benchmarks, and continuation in Years 4 and 5 for successful programs.

A quality pool will be developed as an incentive for providers that exceed quality benchmarks. Quality measures will include metrics that evaluate outcomes and quality of care. These include but are not limited to potentially preventable events such as avoidable emergency room visits, hospitalizations, preventable hospital readmissions and preventable ER visits, and patient satisfaction measures that assess patient safety indicators, care coordination, and getting necessary care quickly.

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

Improving health care for individuals, improving population health, and reducing per capita costs - that is, fixing the current health care delivery system - will require a combination of "top down" and "bottom up" strategies. By using a unique bottom up approach, funds for New Care Models will be invested in models that have been developed by health care stakeholders that are personally invested in the ideas they develop and test.



New Care Models (continued)

While we are aware that there are some similarities between New York's proposed New Care Models and opportunities available through federal CMMI initiatives, we would, through the procurement selection process, assure that we do not fund projects with competing or duplicative aims and that no overlap in funding exists. For example, New York's New Care Models has a broader scope than does the CPCI initiative, which targets improving care for dually-eligible patients only. And, at \$275 million, the competitive funding available to all States through SIM is below the level of funding proposed in New York's New Care Models waiver submission.

In addition, the structure of New York's proposed New Care Models initiative takes a "grass roots" approach in that it would fund promising models of care based on a competitive bid process that would generate proposals from "front line" health care professionals. It allows for testing projects of varying size and scope that fit the needs identified in diverse regions and for diverse populations in the state by the health care provider community, thereby addressing health disparities and fostering collaboration between stakeholders.

New York's request for proposals under New Care Models will solicit projects that tackle both cost and quality issues affecting New York's Medicaid program, with particular attention to projects with promise for improving health care quality and results for the State's most vulnerable patients.



Expand the Vital Access and Safety Net Provider Program

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

At present time, the state’s safety-net institutions (including hospitals, nursing homes and clinics) are operating under tremendous financial pressures and additional pressures will be placed on these providers with upcoming changes to the Affordable Care Act (ACA) and MRT reforms. Without resources, NYS and the stakeholder community have serious concerns that if some of these fragile providers that comprise the Medicaid and uninsured service delivery system fail or do not have adequate resources to reconfigure their operations in a planned way, there could be serious consequences to health care access.

The New York State Department of Health (NYSDOH) has conducted numerous financial analysis studies to examine the state’s safety net community. For example, a recent financial analysis showed:

- Of the 171 nonpublic hospitals, 12 reported a negative operating margin greater than 5 percent. It is important to note that these facilities tend to serve a disproportionate number of the state's Medicare, Medicaid, uninsured and other vulnerable populations.
- Of the 528 nursing homes, 118 reported a negative operating margin greater than 5 percent. While the movement to a new Nursing Home Pricing System will provide critical resources and financial relief to many of these homes, there appears to be at least 40 homes that will not improve and may even worsen.

As evidenced by the following chart, the operating margins of some New York hospitals and nursing homes remains well below the national average. Please note this analysis is for illustrative purposes only and the VAP/Safety Net program will include both public and non-public facilities.

	Financially Challenged	National Average
Hospitals	-10.6%	6.4%
Nursing Homes	-9.0%	1.6%

New York State also conducted an analysis of the nursing home bed needs/access across the various regions of the state. This analysis, which is based upon the 2016 bed needs methodology, shows an estimated shortage of 7,166 nursing home beds in New York. This is comprised of 10,639 under beds (mainly in New York City and Long Island) offset by 3,473 over beds (primarily in Rochester and Erie counties).



Expand the Vital Access and Safety Net Provider Program

Question #2: How will this program help achieve the Triple Aim in New York?

The state has tailored its application review process to ensure the Triple Aim is taken into account. Requests for VAP /Safety Net funding will be evaluated based on the following four criteria:

Facility Financial Viability – The VAP/Safety Net plans must include specific actions for achieving long term financial stability, including benchmarks to measure performance in achieving the goals outlined in these plans.

Community Service Needs – All proposals will be evaluated in context of ensuring the facility is meeting community health needs. It is anticipated that many VAP/Safety Net plans will include a reconfiguration of services from intensive inpatient acute care to providing greater access to, and higher quality primary care services. Moreover, favorable consideration will be provided to hospitals and health systems in both rural and urban communities that have actively collaborated with regional stakeholders in conducting their community health needs assessments and in developing an actionable plan to meet those needs, or are pursuing integration with other providers. Active engagement in regional planning and the support of the regional planning organization (in regions where such organizations are operating) will be an important factor in evaluating applications. In addition, favorable consideration will also be extended to providers that need immediate or shorter term funding to achieve defined operational goals such as a merger, integration, closure, or service reconfiguration. It should be noted that New York State is currently working with stakeholders to align the state's community service plan requirements with the ACA's community health needs assessment requirements.

Quality Care Improvements – The initial analysis of Safety Net facilities indicates that some providers perform in the lower quartile on certain quality performance measures. VAP/Safety Net plans will target improvements in these areas.

Health Equity – A greater weight will be given to those VAP/Safety Net plans that address disparities in health services, or providing care to vulnerable populations who are at greater risk for experiencing poorer health outcomes than the general population. Providers will need to put forth solid VAP/Safety Net plans that provide for their long term financial viability, ability to meet community health needs, and to improve the overall quality of care for patients.



Expand the Vital Access and Safety Net Provider Program

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

The objective of VAP and Safety Net initiatives is to improve access to needed services while reducing Medicaid program costs. In general, the state envisions a health care system which offers efficient high quality patient-centered care through a self sustaining provider network that will reduce health care costs as a whole.

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

Requests for VAP/Safety Net funding will be evaluated based on the criteria noted in Question #2 above. In addition, the state will require each approved VAP/Safety Net plan to include an analysis of how this additional funding will generate a return on investment within the five years of the waiver. These plans will be reviewed and monitored on a regular basis during the five year period to ensure the provider is meeting the objectives outlined in their plans. If a provider is not able to meet the objectives of their plan, funding will be discontinued.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

We are currently working with various stakeholders and industry associations to develop an application process over the next few months. Qualified providers will need to complete an application and submit to the Department for review and approval. The state anticipates funding will be distributed throughout the waiver period based upon the satisfactory completion of various milestones outlined in the approved application.

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

The 2012-13 State Budget authorized up to \$100 million for this purpose, and CMS conceptually approved the state's authorizing state plan to advance this initiative. This funding was a positive first step for the state's safety net providers; however, additional resources are needed under the waiver to maintain a financially viable safety net health care community.



Public Hospital Innovation

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

New York State relies heavily on public hospitals to provide vital care to Medicaid patients and the uninsured. Public hospitals account for \$1.7 billion in Medicaid spending (over a quarter of the total hospital Medicaid spending) and 51 percent of all hospital emergency Medicaid spending in NYS. The success of various NYS MRT and ACA initiatives relies heavily on these critical providers. While ACA will reduce the number of uninsured individuals, the challenges of uncompensated care and access to needed services for Medicaid patients will remain and public hospitals will continue to have to serve those who have nowhere else to go for care.

On the uninsured front, Emergency Medicaid is clearly not the way to “get in front” of these higher cost services for these vulnerable patients, and to further reduce health care disparities for this population. Statewide 31,000 Emergency Medicaid patients are treated annually and 51 percent of these individuals are cared for in public hospitals at a cost of \$267 million per year. Despite this high spending many of these patients lack access to appropriate treatments. In fact, HHC data indicates that uninsured patients only have three encounters per year on average and only .5 of those visits are for primary care in any given year.

The Medicaid expansion under the Affordable Care Act necessitates optimal organization of the public safety net delivery systems so that newly eligible patients can access care. The continued viability of the public safety net systems is also critical because in New York State there will continue to be a significant number of Medicaid, uninsured and other vulnerable patient populations who have historically depended upon these systems for their health care.

At the same time we are asking more of public hospitals, the very funding streams these hospitals have historically relied upon are now at risk. These hospitals rely heavily on DSH funding which is scheduled to be reduced. For example, the DSH cuts enacted in the ACA, and extended in recent legislation, will result in nearly \$2.3 billion in losses in DSH funding to HHC over eight years beginning in 2014. Such losses are likely to occur for other public hospitals in New York State as well.



Public Hospital Innovation (continued)

In terms of “current state” from the operational perspective, the waiver funding will build on existing successes in HHC and other public hospitals. Public hospitals in NYS have a mission to provide the highest quality health care for all New Yorkers regardless of their ability to pay. In order to maintain this important mission, HHC has adopted as one of its strategic goals – the Triple Aim. This strong imperative for improving quality of care, improving the health of the patients and communities it serves and reducing costs has driven HHC’s efforts to build and develop an integrated delivery system that has demonstrated achievement and accountability of real and measurable improvements. These include:

- All of HHC’s primary care sites have attained NCQA designation as Level 3 Patient Centered Medical Homes;
- HHC was an early adopter of use of an enterprise-wide electronic medical record. All patient data is in one electronic registry which has enabled coordination of care and has fostered outcome accountability;
- HHC has implemented a front-line staff, team based approach to performance improvement using LEAN to redesign processes around patients and reduce waste. Over the last 5 years improvement work has resulted in \$225 million in savings and new revenues;
- HHC publicly shares its performance on quality and safety measures against state and national standards on its website, “HHC in Focus”, and
- HHC’s health plan, MetroPlus, which has more than 425,000 members (the third largest in the State), has been consistently rated number 1 or in the highest tier of health plans for quality and patient satisfaction by New York State. That recognition is a reflection of the quality of care provided by HHC as most of MetroPlus’ members receive their care within the HHC system. MetroPlus also has the lowest administrative costs among health plans in the state.

However, significant challenges remain. HHC is keenly aware that despite its success towards achieving its goals and those of New York State, its current performance in certain areas is not at the level needed. Access to care when and where it is needed is a key domain of quality; and one, especially in primary care, where HHC is challenged. While HHC is working hard in this area to redesign its existing operations to create additional capacity, external support and resources are needed to assist this vital access provider to ensure that expanded coverage among those in communities served by HHC results in expanded access to primary care. HHC’s successful attainment of NCQA designation is a reflection of its efforts in this area. But more must be done including partnerships with community health centers, behavioral health providers, housing agencies and other organizations to expand access to this most critical building block for improved health outcomes.



Public Hospital Innovation (continued)

HHC also must do more in the area of readmission for chronic disease. Although the public hospitals' mortality rates for AMI, Heart Failure and Pneumonia are at or above national averages; their readmissions rates for these conditions have lagged behind. HHC hospitals have achieved significant improvements for Heart Failure, but have been hampered in their efforts by the combined factors of homelessness or housing instability, inadequate access to primary care post discharge and language and literacy challenges associated with the diverse populations they serve.

Question #2: How will this program help achieve the Triple Aim in New York?

The Triple Aim goals of better care for individuals, better health for populations, and reduced per-capita costs will be vigorously pursued by the Public Hospital Innovation initiative, which will fund projects that meet rigorous criteria designed around the Triple Aim through a competitive bid process. Waiver funding will be specifically used to plug existing gaps in public hospital systems related to the continued need for additional care management and targeted primary care capacity for the Medicaid population and the uninsured. The demonstration program that will provide “pre-emergency” Medicaid services to both uninsured and Medicaid members to provide these patients with access to: 1) culturally appropriate care management focused in the higher risk communities; 2) improved discharge planning for higher need patients and 3) Primary Care Expansion through integrated Patient Centered Medical Homes with co-located behavioral health services. Based on existing literature it is expected these targeted investments will improve patients' health and reduce overall Medicaid spending. As this new capacity will be made available to Medicaid beneficiaries and other patients being treated in the public hospital system the clinical benefits and savings will accrue in both emergency Medicaid and regular Medicaid.

An improved primary and behavioral health care management and primary care treatment capacity is critical to reduce, and eventually replace, existing high cost revolving door ED, inpatient and dialysis services. For instance, the emergency Medicaid program currently pays over \$3 million for dialysis services in New York State for 228 patients. Some of this dialysis treatment is specifically related to end stage renal disease for uninsured patients whose chronic conditions could have been better managed had they been able to consistently and regularly access primary care and medications for diabetes and other treatable chronic conditions.



Public Hospital Innovation (continued)

To promote quality and reduce health care disparities these public hospital proposals will:

- Increase focused culturally competent care management for ED and Inpatient higher risk patients;
- Increase discharge planning and transitional support for high risk patients;
- Increase primary care capacity in underserved areas through expanded hours, new sites, partnerships with community health center and behavioral health providers, and strengthening required elements of Patient Centered Medical Homes.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

The public hospitals at the future will have greater capacity to provide real time access to primary care for in the highest risk neighborhoods in New York City and New York State. Members receiving services at public hospitals, irrespective of pay source, will get prioritized (and if needed immediate) access to the right kinds of care and care management. Inappropriate admissions to acute care beds from the emergency department will be eliminated. The sickest and highest risk patients will have a care manager assigned to them that speaks their language, understands their cultural and can help them get to a primary care doctor and any needed specialty providers including help for mental health and substance abuse problems. Doctors will work as members of specialized teams to deal with the higher risk diagnoses to work hard on reducing avoidable admissions and readmissions. Public hospitals will be better networked with existing community based providers of health care, behavioral health care, housing and social services, again in the highest risk communities of the State to better coordinate care and keep members utilizing ambulatory services instead of over relying on ED and inpatient care. Patients in some of the highest risk communities of the city and state will have closer and more immediate access to new programs providing integrated primary care that also include critical specialty capacity like psychiatry and addiction medicine.

Overall, when this and other waiver programs are implemented, the public hospitals will have new care capacities and new fiscal incentives to operate and better utilize primary care and care management instead of being required to meet certain inpatient occupancy thresholds to keep the overall operations running. The fiscal imperatives and clinical focus will be aligned toward improving health outcomes and reducing unnecessary cost.



Public Hospital Innovation (continued)

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

The public hospitals will commit to responsibility for building these new services (with community partners) with significant state oversight.

The state will monitor access patterns for these patients and measure the increase in primary care against the decrease in ED and inpatient services using industry standard metrics (e.g., HEDIS, RAND, QARR) and metrics newly developed for the purpose of this reinvestment program. Resources made available through the waiver will be used, in part, to develop and test new measures for the purpose of this project and to develop data systems for collecting and reporting metrics on the uninsured. To identify potential health disparities, all measures will be stratified by age, race, gender, and region. Taken together, these metrics, drawn largely from the set of Medicaid Redesign Quality Measures, are designed to track pre- and post-implementation progress toward achieving the goals of this MRT reinvestment program to improve quality of care, improve population health, and reduce per capita costs.

Improved Access to Primary Care: A number of standard and newly developed metrics will be employed to assess progress toward achieving state of the art care management, primary care and behavioral health capacity to the high risk uninsured and Medicaid populations served by public hospitals. These include measurement to assess improvements and increases in access to primary care, initiation in substance abuse treatment, engagement in mental health treatment, and substance abuse outpatient follow-up, access to primary care and behavioral health providers within 3-5 days of demand, enrollees in patient-centered medical homes, the percent of high cost and high need cases enrolled in health homes as a result of care coordination and care management, and increased primary care and behavioral health ambulatory capacity.

Improved Quality of Care, Preventable Events, and Patient-Centered Metrics: Improvements in care management, care transitions and primary and behavioral health capacity (and care received in Health Home and PCMH settings) will result in reductions in the use of high cost ED and inpatient services. Standard quality of care metrics to monitor progress in these areas include assessment of the decrease in ED visits, reduced hospital admissions and length of stay, and improved disease management for conditions such as diabetes, heart disease, pneumonia, and asthma, and reduction in dialysis services.



Public Hospital Innovation (continued)

Additional quality measures of importance include metrics to assess the reduction in avoidable hospitalization for ambulatory sensitive conditions, and reductions in avoidable and preventable hospital ED visits and hospital readmissions. Patient-centered metrics will include MRT Redesign measures of receiving care quickly, getting needed care, and patient perspective on care coordination.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

Initial projects will be funded with targeted dollars allocated through a competitive procurement process. Also a quality pool will be developed as an incentive for selected providers that exceed quality benchmarks. The "flow" of funds to approved projects will depend in part on the awarded project. Planning dollars and operational dollars would only be provided to awarded projects through the competitive process; quality pool funds would only flow to selected projects that also exceed outcome benchmarks. Funding would be provided in phases based on the achievement of specified and measurable benchmarks and program parameters. Quality measures will include previously described metrics that evaluate outcomes and quality of care.

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

Funds to meet the programmatic aims are these efforts are not specifically available either because of issues with coverage limitations with respect to the target population (e.g., emergency MA only or patient does not meet health home criteria, etc.) or specific funding is not available for the proposed project (e.g., additional primary care capacity, home visiting etc.). Where funds are partially available (e.g., health homes etc.) funding will be carefully orchestrated in both the funding availability solicitations and during program oversight to assure waiver dollars will augment rather than duplicate existing efforts.



Medicaid Supportive Housing Expansion

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

New York State is plagued by a lack of supportive housing and as a result Medicaid is wasting money. There is compelling evidence that for people coping with chronic illness or disability and behavioral health challenges, the lack of stable housing often results in avoidable health care utilization and, in turn, avoidable Medicaid expenses. Moreover, the lack of affordable housing, in combination with accessible health care, continues to be an obstacle to serving individuals in the most integrated setting. This includes individuals in nursing homes and other long term care settings, who cannot be discharged because they lack a place to live, as well as homeless individuals and those in shelters whose chronic health and behavioral health conditions lead to overuse of emergency departments and hospital inpatient care. Transitioning individuals into supportive housing dramatically reduces immediate and long-term spending for Medicaid reimbursable expenses, as well as spending on other public programs. By increasing the availability of supportive housing for high-need Medicaid beneficiaries, there is significant opportunity to reduce Medicaid costs and improve the quality of care for these individuals.

Question #2: How will this program help achieve the Triple Aim in New York?

Access to supportive housing services is of paramount importance to achieve the Triple Aim of better health, better care, and lower costs for traditionally underserved populations.

Better Health, Better Care

There is a growing national recognition that addressing the social determinants of health is critical for improving health while reducing health care costs. This is most evident in the matter of housing. People who are homeless or lack stable housing face multiple health risks, die younger, have less access to primary care, and are frequent users of expensive hospital services. Among those New York City Medicaid patients at highest risk for future costly hospital admissions, as predicted by a validated algorithm, a full 60 percent were homeless or precariously housed.

Additional supportive housing services will also reduce health disparities by focusing on a diverse population of low-income New Yorkers. Racial minorities, including African-Americans, Hispanics, and Native Americans are overrepresented among those who are homeless and marginally housed, and stand to benefit the most from supportive housing services. In addition, focusing on the Health Home eligible population will have the ancillary benefit of contributing to reducing health disparities among the minority community.



Medicaid Supportive Housing Expansion (continued)

For example, of the Health Home eligible population, over 20 percent are African-American and over 26 percent are Hispanic. Increased funding for supportive housing services for the racial and ethnic minority population will contribute to the state's efforts at reducing health care disparities.

Lower Costs

The lack of appropriate supportive housing, especially in New York's urban areas, is a major driver of unnecessary Medicaid spending. For every individual served under this program, it is estimated to save Medicaid costs by approximately \$16,281 - \$31,291 annually per person¹⁴, with savings ranging by the types of populations and disabilities served and intensity of targeting. Preliminary estimates suggest that Medicaid savings would total between \$142 million - \$273 million annually, totaling between \$711 million - \$1.3 billion over a five-year period.

Over a decade of independent research has shown that transitioning individuals into supportive housing dramatically reduces immediate and long-term spending for Medicaid reimbursable expenses, as well as spending on other public programs. This is a fundamental premise of the U.S. Department of Justice's vigorous enforcement activities to assure the availability of community living options for people with disabilities. In New York, supportive housing costs \$47 per day while it costs \$437 a day in a psychiatric hospital, \$755 in an inpatient hospital, \$68 in a homeless shelter, and \$129 for jail.² By increasing the availability of supportive housing for high-need Medicaid beneficiaries, there is a significant opportunity to reduce Medicaid costs and improve the quality of care for these individuals.

A preliminary analysis of 28,724 recipients in need of supportive housing found a total of over \$1 billion in annual Medicaid expenditures, including \$212 million on inpatient hospital care, \$5 million on emergency department services and \$266 million on long term care services.³ Supportive housing services have the potential to decrease these costs dramatically – producing millions in Medicaid savings.

For example, multiple national studies have found reductions in emergency department (ED) and inpatient costs averaging 60 percent, potentially saving New York's Medicaid program over \$650 million over five years in ED and inpatient costs alone. Clearly, expanding the availability of supportive needs is an integral component to attaining Medicaid cost containment.



Medicaid Supportive Housing Expansion (continued)

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

After the completion of this project, New York will have a more secure foundation to house its high cost Medicaid populations. Specifically, individuals that receive supportive housing services through this program will receive comprehensive “support services”, and a permanent place to live. By increasing the availability of supportive housing for high-need Medicaid beneficiaries, New York will experience a significant reduction in Medicaid costs and vast improvement in the quality of care for these individuals.

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

New York’s Supportive Housing program will monitor placement to assure that only eligible individuals, as outlined on page 60 of our MRT document, receive supportive housing services through this program. New York State and New York City have extensive experience in managing a gate keeping function to assure that priority populations are placed in supported housing units. The State and City, going back to 1990, have implemented a series of New York/New York agreements targeted to the shelter and street homeless population. The NYC Human Resource Administration reviews each request for housing and certifies that the individual meets the target population criteria prior to placement. In 2005, under the NY/NY III agreement, this gate keeping function was strengthened to target long stay shelter and street homeless. The NYS waiver proposal will use a similar gate keeping function; in this case the admission criteria would be high cost Medicaid users. Medicaid claims and encounter data would be used to review the referral. For NYC, the state would work cooperatively with NYC government, Health Homes and managed care plans to manage this function.

Outside of NYC the state could manage the gate keeping directly in cooperation with Health Homes and managed care plans. Local government could choose to participate in the process. The initial target group for health home enrollment is high Medicaid users, so this will be a natural pool to generate referrals. The health home will be responsible for developing and overseeing the integrated plan of care for treatment and support.



Medicaid Supportive Housing Expansion (continued)

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

New York seeks to dedicate \$150 million annually, totaling \$750 million over five years, to expand access to supportive housing services. Under this proposal, two programs would be created – the Supportive Housing Capital Expansion Program, totaling \$75 million annually, to fund capital projects, and the Supportive Housing Services Program, totaling \$75 million annually, to provide supportive housing services.

Funds must target high cost, high need Medicaid members who require supportive services to live independently. Funds would be distributed through a variety of state and local housing agencies via a competitive request for proposal approach. Funds would be distributed to eligible applicants on a competitive Request for Proposal (RFP) process. Sustainable projects, with the greatest Medicaid return-on-investment (ROI), would be prioritized over other projects. Eligible applicants may include, but are not limited to, for profit and non-profit housing developers, and private nonprofit organizations. New York State agency partners may include: the Office of Mental Health (OMH), the Office of Temporary and Disability Assistance (OTDA), the AIDS Institute within the Department of Health, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and New York State Homes and Community Renewal (HCR).

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

This proposal is one component of New York's greater commitment to support Supportive Housing. Currently, multiple agencies throughout the state fund supportive housing programs. New York State has invested more than \$350 million annually in these efforts because the program works – it improves quality care and lowers health care costs. Despite New York's commitment, we continue to experience need whereby thousands of New Yorkers lack housing and supportive services. As a result, these individuals continue to be homeless or live in institutions or other inappropriate settings because of the lack of affordable, accessible housing options in the community.



Long Term Care Transformation and Integration to Managed Care

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

The core problems in health care delivery that the long term care investment projects are trying to address is the myriad of uncoordinated fee for service long term care programs in New York. All the reinvestment efforts are targeted to help advance the "care management for all" agenda. The projects include efforts to help nursing homes transition from the reliance on Medicaid fee for service payments for a vast majority of their revenue to a managed care capitation environment. Many nursing homes have made capital investments in their physical plants under the current certificate of need process and specific reimbursement policies. The waiver of the specific managed care payment requirements in the request will allow for enhanced stability for that provider sector. Other reinvestment items will help the long term care system increase the percentage of spending on the home and community area and decrease the future spending on nursing home care. Specifically, the investment in the NY Connects program and the ombudsman program will allow for truly informed family and consumer choices.

Question #2: How will this program help achieve the Triple Aim in New York?

The state strongly believes that successful implementation of "care management for all" will help achieve the Triple Aim. In particular, program investments in HIT for the MLTC plans will help the plans and their networks meet the requirements of CMS for information sharing and better overall communication which will improve patient care. As the plans migrate from the semi-annual assessment of members or SAAM assessment tool to the new universal assessment system, plans and their network partners will have implementation costs including both hardware and software. In addition, the plans will be expected to eventually connect with the Regional Health Information Organizations (RHIOs). The state of the HIT readiness in the long term care provider sector clearly requires this investment as well as other efforts.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

The state's long term care system will be more cohesive and easier to understand for both patients and their families. A fully functional Aging and Disability network will allow for families and patients to make informed choices of services to help them prevent inappropriate institutional placement. In addition, the investment in assisted living programs for Medicaid recipients will further the rebalancing goals articulated in the Affordable Care Act. This investment will allow thousands of nursing eligible recipients to be diverted to less costly settings.



Long Term Care Transformation and Integration to Managed Care

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

The Managed Long Term Care plans and their networks will be measured on meeting basic contract standards as well as quality metrics. If plans fail to meet certain metrics there will be reimbursement implications. The state is establishing quality incentives and plans who do not meet certain thresholds will not receive quality payments. The ALP capital funding will be made available through reimbursement-based contracts and if the work is not completed, the money will be not available. The HIT payments will be made once certain deliverables are met. The Aging and Disability Resource Centers (NY Connects) will have strict contract requirements and measurable deliverables and will be closely monitored by the State Office for Aging as well as the Department of Health. Both the quality improvement program and the ombudsman program will use contracts that will pay based on the vendor meeting certain benchmarks.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

Each project will have to follow the state procurement process.

- 1) Nursing Home Capital: If the waiver is granted the current federally approved process will be retained.
- 2) ALP Capital: A Request for Proposals will be issued for new ALP providers. These providers are being selected by an "Opportunity for Development process" which is available on the MRT website
- 3) NY Connects: These funds will be administered by a modified request for proposal issued by the NYS Office for Aging in conjunction with the Department of Health
- 4) Quality Improvement Program: This vendor will be identified by either a sole source justification or a request for proposal per the state procurement guidelines.
- 5) HIT: These funds will be allocated to qualified managed long term care plans (MLTC) and fully integrated duals advantaged plans (FIDA) based on a formula of covered lives and need.
- 6) Ombudsman Program: A request for proposal process will be used to select a qualified applicant for this function.



Long Term Care Transformation and Integration to Managed Care

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

All of these projects are essential to meet the state health care/ long term care reform goals. The state has made only modest investments in the NY Connect program due to budget constraints and this request will allow the program to grow to scale and start in the City of New York. There is limited state funding available for the other projects. The efforts relate to both the community first choice option as well as the balancing incentive program authorized by the ACA. The ombudsman and quality assurance projects will work in conjunction with the dual integration financing alignment efforts sponsored by the CMS innovations office.



Capital Stabilization for Safety Net Hospitals

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

In underserved, inner-city communities and in areas that are geographically isolated, the hospital is the health care delivery system. In developing recommendations for transforming the Medicaid program the MRT recognized the importance of preserving and strengthening safety net providers that are essential to preserving access to care in their communities.

Many safety net institutions have limited financial resources to respond to the call for change and often have to make choices every day as to whether to fund medical malpractice or meet payroll or pay vendors. This prohibits meaningful participation in development of clinically integrated delivery systems in communities that are in clear need of improved population health. New York State has a number of safety net hospitals in this situation and while there are well defined specific problems in the downstate areas, particularly in Brooklyn, there are other providers in rural and even some suburban areas of New York with comparable financial constraints.

Hospital margins in New York are well below national benchmarks. An analysis focused on hospitals that derive more than 30% of their net patient revenue from Medicaid, excluding disproportionate share hospital (DSH) payments, all measures of financial operating strength, liquidity (cash availability), and balance sheet viability are exponentially worse. Unless something significant is done to address the realities of the New York State health care delivery system entire communities of care could collapse. That is why this waiver amendment is so important.

***	NY Medicaid Dependent Hospitals	Other Hospitals	All Hospitals	National Benchmark**
Financial Condition				
Operating Margins	-3.2%	1.9%	0.6%	3.0%
Total Margin	-2.9%	2.2%	0.9%	N/A
Current Ratio	1.34	1.57	1.48	1.75
Equity Financing Ratio	12%	27%	24%	30%
Quality				
% of Patients Reporting Best Experience of Care	53%	58%	57%	
Medicare Risk-Adjusted Readmission Rates	24.5%	22.8%	23.1%	

* Medicaid-dependent hospitals consistently derive more than 30% of their net patient revenue from Medicaid, not including Medicaid DSH payments. There are 36 general, acute care Medicaid-dependent hospitals in New York, 24 voluntary and 12 public. ** Benchmarks are thresholds used by the FHA in designating applicants for hospital mortgage insurance as low risk. *** Financial measures are 2008-2010 averages; quality measures were derived from the May 2012 release of Hospital Compare, the hospital performance web site maintained by the Centers for Medicare & Medicaid Services in the U.S. Department of Health & Human Services. Data provided by Greater New York Hospital Association (GNYHA).



Capital Stabilization for Safety Net Hospitals (continued)

Question #2: How will this program help achieve the Triple Aim in New York?

The Triple Aim is only possible if the safety net is preserved and enhanced. This program will provide an infusion of funding to meet the objective of facilitating long term structural sustainability. New York State safety net providers are, by definition, ill prepared to participate financially in transformations/network development and yet are well positioned to make meaningful progress in changing models of care for our most chronically ill and underserved populations and communities. This will allow the safety net hospitals in New York's communities to develop and participate in development of integrated delivery networks that provide better and more access to appropriate care in the community, along with providing better quality at lower costs. With the chronic balance sheets that many safety net hospitals have, abrupt closure or financial ruin looms and the development of meaningful partnerships are prevented.

This funding is essential to give safety net hospitals the opportunity for thoughtful reconfiguration, to avoid precipitous hospital closures in high need communities, and to prevent significant disruptions in access for Medicaid patients.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

The goal is to provide an opportunity for some of New York's neediest communities to have access to health care that is not entirely organized around the emergency department of a hospital and inpatient procedures. We would aspire to create a well organized system of primary and specialty care services available to the community in convenient locations and at convenient hours staffed with health care professionals focused on preventing the chronic diseases that ravage these communities. This would be supported by quality inpatient care for inpatient care services. Additionally, this aspirational model will be sustainable financially for providers. For example in Brooklyn, we have 2 if not 3 failing hospitals, with appropriate funding support, these hospitals will be able to partner with other acute care and outpatient providers and physicians to rationalize services, perhaps down size and reconfigure inpatient capacity in a way that is sustainable. Not only will this require funding to support both investments to facilitate new partnerships, but also to invest development of physician and outpatient services.



Capital Stabilization for Safety Net Hospitals (continued)

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

The Department of Health expects to award contracts through a Request for Applications (RFA) process to qualified organizations that meet the technical specifications as outlined in the application. In the case of regional planning, DOH may need to foster development of qualified organizations as they are discrete and organic to each region. Each applicant must fulfill numerous requirements to receive funding, including a description of their background, experience, and structure which qualifies them as bidders, and, if applicable, its subcontractor(s) ability to undertake the functions and activities required. Additionally, there will be outcome and quality metrics associated with each application. All bidders must detail their proposed approach and provide a completed work plan outlining how they will address the program requirements and detail when activities will be completed. Successful applicants will be required to submit quarterly reports that describe grant activities and evidence that they are meeting all requirements at specified timeframes. Providers that fail to meet agreed upon deliverables will jeopardize future funding as the State can exercise its option to cancel the contract due to unsatisfactory performance.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

As stated above, the Department of Health will award contracts through a RFA process to qualified organizations that meet the technical specifications as outlined in the application. Each applicant must fulfill numerous requirements to receive funding, including a description of their background, experience, and structure which qualifies them as bidders, and, if applicable, its subcontractor(s) ability to undertake the functions and activities required. Also, all bidders must detail their proposed approach and provide a completed work plan outlining how they will address all the program requirements.

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

The funds are required to assist safety net hospitals and communities to stabilize existing hospitals to allow for development of new systems of care. We are not aware of other funding for this purpose but we will coordinate with existing funding where available.



Hospital Transition

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

Answer #1: The ACA and MRT reforms will require hospitals to develop new financial and business models that are significantly different from today's model where reimbursement systems largely incentivize providers to focus on the volume of services they provide rather than service efficacy. This program will provide an opportunity for hospitals to be supported through this transition.

This program will provide a platform for building integrated delivery systems that will better promote good preventive care and improved community health outcomes. There is clearly room for improvement as the state ranks 18th (24th in 2010) out of all states for overall health system quality and ranks 50th among all states for avoidable hospital use and costs. A report issued by the New York State Health Foundation found hospital readmissions cost New York \$3.7 billion per year, with nearly 1 in 7 initial hospital stays resulting in a readmission. Many of these readmissions are the result of poor access in the community to follow up care, mental health and substance abuse co-morbidities that impede compliance with treatment regimens, and lack of social support services.

New York State hospitals have both financial and liquidity indicators well below the national averages, with some providers in economically challenged communities struggling for financial survival. In 2010, median operating margins for hospitals in New York State were break even at best and hospitals with Medicaid patient loads in the highest quartile ran an average operating margin of negative 1.3 percent. New York's rural hospitals had a total operating margin of negative 0.3 percent.¹

Liquidity, which is key to enabling investment for reform, remains challenging for New York hospitals which lags significantly behind national median ratings and is particularly problematic in certain regions of the state.

Hospitals are necessary partners and/or leaders in developing new clinically integrated, health care network delivery systems and right sizing the number of inpatient hospital beds for their communities.

¹ Data provided by HANYS and GNYHA



Hospital Transition (continued)

Question #2: How will this program help achieve the Triple Aim in New York?

Answer #2: Integrated delivery systems are the models that best serve increased access to high quality, appropriate, and affordable care for New York's communities. Hospitals are well positioned to either develop or participate in these networks but given the current delivery systems and financial condition, transition investment is needed. This program will provide such transitional support that can be tailored to a particular community's need. Some geographies of the State have the solid foundations of integrated delivery networks either developed by hospitals or with significant participation by hospitals. This program seeks to support further development of these networks to include more component pieces or to replicate the knowledge in communities that need integration.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

Answer #3: The goal is to transform New York State's health care delivery system into one that is completely integrated and provides access and coordinated quality care to every New Yorker. There is a need to shift emphasis from institutional care to a system that has a foundation of primary and preventive care. To accomplish this goal, New York needs investment to build the integrated delivery system that improves population health and outcomes but also provides a financially sustainable delivery network.

Key elements associated with the future integrated health care delivery systems in New York State are:

- Fully integrated provider network responsible for community health outcomes;
- A primary focus on quality and service outcomes;
- Organizations with sufficient size to take advantage of economies of scale;
- Significant support from well developed health information technology;
- Operational flexibility and nimbleness in resource allocation;
- Progressive governance and management oversight.



Hospital Transition (continued)

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

Answer #4: The Department of Health will award contracts through a competitive Request for Applications (RFA) process to qualified organizations that meet the technical specifications as outlined in the application. Each applicant must fulfill numerous requirements to receive funding, including a description of their background, experience, and structure which qualifies them as bidders, and, if applicable, its subcontractor(s) ability to undertake the functions and activities required. Additionally, there will be outcome and quality metrics associated with each application.

All bidders must detail their proposed approach and provide a completed work plan outlining how they will address the program requirements and detail when activities will be completed. Successful applicants will be required to submit quarterly reports that describe grant activities and evidence that they are meeting all requirements at specified timeframes. Providers that fail to meet agreed upon deliverables will jeopardize future funding as the State can exercise its option to cancel the contract due to unsatisfactory performance.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

Answer #5: As stated above, the Department of Health will award contracts through a competitive RFA process to qualified organizations that meet the technical specifications as outlined in the application. Each applicant must fulfill numerous requirements to receive funding, including a description of their background, experience, and structure which qualifies them as bidders, and, if applicable, its subcontractor(s) ability to undertake the functions and activities required. Also, all bidders must detail their proposed approach and provide a completed work plan outlining how they will address all the program requirements.

The contracts will be for a maximum contract of five years, subject to the sole option of the State, satisfactory performance, and availability of funds. Payments to contractors will be made based on the work plan and deliverables.



Hospital Transition (continued)

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

Answer #6: The funds are required to assist the health care delivery system pay for development of new systems and relationships to best serve the community. While Federal CMMI funds are available for this purpose, the scale of need outstrips that opportunity. New York State has limited funds. We will, however, coordinate with existing funding, where available.



Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform

Question #1: What are the core problems and the "current state" in health care delivery that these workforce programs address?

State and federal health reform efforts that place increasing emphasis on development of a sufficiently sized and adequately trained workforce are crucial to achieving the goals of transforming the health care delivery system to achieve the Triple Aim. While New York State spends more on health care than any other state, it has the highest rate of avoidable hospitalizations and is in the 'middle of the pack' in terms of overall quality of care, based on standardized national measures. This poor performance is, in part, attributed to the fact that many patients, particularly those who are the most complex and costly, are not well-connected to primary care, a medical home, or a coordinated care setting. The ACA provides opportunities to transform the health care delivery system, addressing isolated care delivery structures and lack of systemic care coordination through implementation of new models of integrated care delivery. In addition, a substantial mal-distribution exists related to primary care physicians and other clinicians statewide, with most upstate regions having much lower numbers of primary care physicians per capita than downstate regions.

For example, 450 full-time equivalent (FTE) primary care physicians – and many more clinicians of other types - would be needed to remove all primary care shortage designations in New York, but over 1,100 primary care physicians are needed to achieve the desired 2,000:1 (overutilization threshold) population to primary care provider ratio in all shortage areas.

Question #2: How will this program help achieve the Triple Aim in New York?

Improving health care quality and access by placing an increasing emphasis on the development of a sufficiently sized, evenly deployed and adequately trained workforce helps achieve the Triple Aim.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples.

In the future, New York State will have a right-sized, adequately trained, appropriately distributed health workforce that meets the needs of all NYS residents. We will achieve this by:

- providing new skills, such as care coordination, to realize the goals of expanding PCMH and Health Homes in New York State;
- training personal care attendants to become home health aides;



Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform

- sensitizing care management teams to cultural differences among patients that may impact patient willingness to access services and accept and follow treatment regimens;
- promoting interdisciplinary team based care;
- promoting Labor-Management Partnerships;
- building Health Care Career Ladders;
- expanding the availability of incentives such as Doctors Across New York and the Primary Care Service Corps, to health professionals who choose to serve in underserved areas;
- making available real-time data on health workforce supply, the educational pipeline, and demand for health workers as well as statewide system for monitoring health workforce demand across all health sectors;
- creating ongoing “just-in-time” data on the roles, responsibilities, qualifications and training needed for new and emerging job titles across all healthcare sectors, the comparative effectiveness of various health care services, and a better understanding of the barriers to oral health services in NYS and
- assisting facilities in underserved areas that seek to recruit and retain needed health professionals by making available the regional information they need when they need it.

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

The state will assure program effectiveness by (1) developing performance based contracts and reimburse as performance benchmarks are attained, or (2) otherwise, as appropriate, recover reimbursements where benchmarks are not attained. Contracts will also include non-renewal clauses and financial penalties, as appropriate, for those who do not achieve stated goals.

With regard to workforce incentives, state contracts with individual providers will build in substantial penalties for those who do not complete service obligations. These penalties can be based on those currently in force under the federal National Health Service Corps (NHSC).



Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

It is anticipated that funds will flow in the same manner as currently under the more limited Health Workforce Retraining Initiative (HWRI) and the various state workforce incentive programs, i.e., via a Request for Proposals or application process under the standard rules and regulations of NY state procurements.

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

It is anticipated that current HWRI and workforce incentive funding by New York State will continue, but will be augmented by waiver funding. This will be necessary in achieving expanded access to health care services, and the attendant need for additional providers, concomitant with meeting the increased demand for health services, under the ACA.

Funds received under this waiver will also augment current federal workforce incentive programs such as the National Health Service Corps and the State Loan Repayment Program. DOH tracks these clinicians and assure that newly-obligated clinicians will "fill in the gaps" by being deployed to sites that still have a need for such clinicians. No other funds are available at the state or national level to fund these efforts.



Public Health Innovation

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

The current state is that these programs are not viewed as health care delivery. We are trying to change that paradigm by demonstrating that community based prevention efforts can improve health and save money. Chronic diseases – such as heart disease, cancer, stroke, and diabetes – are responsible for 7 of 10 deaths among Americans each year and account for 75 percent of the nation’s health spending. Often due to economic, social, and physical factors, too many New Yorkers engage in behaviors such as tobacco use, poor diet, physical inactivity, and alcohol abuse that lead to poor health. Actions to prevent chronic disease (such as pre-diabetes interventions) and prevent exacerbation of disease (such as home-based interventions for asthma) will be implemented to promote health and reduce costs. It has been estimated that \$100 to \$110 billion of New York’s \$160 billion health care bill goes for hospitalizations, medications, medical treatments, and long-term care for patients with one or more chronic diseases, a group of patients that is expanding rapidly. The growing financial impact of chronic disease on the health care system is pervasive and far-reaching. Examples of the annual cost of chronic disease in New York, attributable to both direct medical costs and lost productivity include:

- o Diabetes — \$12 billion
- o Asthma — \$1.3 billion

Question #2: How will this program help achieve the Triple Aim in New York?

New York State will integrate community based public health prevention programs into the Medicaid program. These evidence based strategies will advance New York’s efforts to achieve the Triple Aim of improved quality, better health and reduced health care costs. Effective integration of community based public health as part of the broader health care system inclusive of local health departments and clinical providers will promote population health and reduce systemic costs including Medicaid costs of care and treatment. By concentrating on the underlying drivers of chronic disease, New York will move from today’s sick-care system to a true “health care” system that encourages health and well-being.

Moreover, a 2009 report by the Trust for America’s Health (TFAH) estimates that an investment of \$10 per capita in a series of strategic community-based disease prevention programs aimed at improving physical activity and nutrition and preventing smoking and other tobacco use could achieve a return on investment (ROI) of 1.37:1 in one year and 7.04:1 in five years. These savings would be realized in reduced health care expenditures by Medicaid and are fully consistent with recent support of preventive care measures as part of the Affordable Care Act.



Public Health Innovation (continued)

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

The health care system will be viewed more broadly to include community based prevention. New York State's delivery system will for the first time integrate community based public health prevention programs as an integral component of the Medicaid program. The future vision is a health care system that effectively addressed preventable chronic conditions to both improve health and well being and ensure long-term reductions in morbidity and mortality and as a result health system costs. According to the IOM, 80% of heart disease and type-2 diabetes, and 40% of cancer could be prevented by people exercising more, eating better, and avoiding tobacco. Getting people to exercise more, eat better and avoid tobacco is not something that the health care system does well. By concentrating on the underlying drivers of chronic disease, New York will move from today's sick-care system to a true "health care" system that encourages health and well-being.

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

The public health initiatives include detailed metrics for purposes of measuring success and failure. These measures will be carefully tracked to evaluate the impact of these innovative care models. Where success is apparent this information will be shared as a best practice; where metrics suggest that the programs are not realized the intended outcomes actions will be taken to evaluate the programs, effectiveness of implementation and possible refinements to address any identified deficiencies.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

The public health innovation programs will initially be funded with grant dollars allocated through a competitive procurement process. These grant funded initiatives are critical to both creating the infrastructure needed to support these initiatives and to formally develop the evidence base and create a set of best practices for moving forward.



Public Health Innovation (continued)

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

Public health prevention, particularly funding services rendered by paraprofessionals has not traditionally been eligible for reimbursement by Medicaid. There are not other federal funds available for these activities. We have limited state funds. We will however coordinate with existing funding where available.



Regional Health Planning

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

In the context of dramatic changes in the delivery system driven by New York's MRT and the Affordable Care Act (ACA), collaborative, regional health planning will be an essential element of New York's effort to achieve the Triple Aim. A variety of factors demand a robust regional planning infrastructure in New York State:

- New York's health care delivery system and the health status of its residents vary greatly by region and even community. Health care is often fragmented along the continuum, and behavioral health care is too often separate from physical health care. While some regions of the state have an abundance of physicians and primary care practitioners, others are experiencing shortages
- With one million New Yorkers soon to be newly-insured under the ACA, regional strategies to ensure access to high quality primary care will be needed.
- As health care providers position themselves to take advantage of new payment arrangements and avoid reimbursement penalties (e.g., for readmissions), there is a risk that certain populations and communities will be neglected and that essential providers will be left behind. There is also a risk that consolidation of providers will lead to reduced access and upward pressure on payment rates.
- The impact of new payment mechanisms and new models of care can be optimized (and pitfalls avoided) through the work of regional collaboratives, supported by reliable data, to address population health and disparities concerns, to facilitate collaborations among providers along the continuum of care, and to align payment incentives to promote desired aims.
- New York has required hospitals and local health departments to collaborate on their respective community service plans and community health assessments. Similarly, the ACA requires hospitals to conduct community health needs assessments. However, hospitals and local health departments cannot alone improve the health of communities. Effective collaborations among multiple stakeholders (e.g., consumers, payers, employers, providers, local health departments and others) are needed to identify, and implement strategies to address, community health needs.
- Underlying all of these initiatives is the imperative to reduce the per capita cost of health care, while improving health outcomes and status. New York's global cap on Medicaid provides a brake on spending. Keeping costs under the cap and bending the cost curve for other payers demands collaboration among multiple stakeholders based on upon reliable data.



Regional Health Planning (continued)

While New York State has some very strong existing regional and local organizations provide invaluable contributions to the health of their communities and their local delivery systems, there are many regions, however, where health planning activities are limited in scope, fragmented, and not connected to an overall regional vision addressing each element of the Triple Aim. The funds requested under this waiver will help expand and strengthen broad-based regional planning throughout the state.

Question #2: How will this program help achieve the Triple Aim in New York?

This program will support new updated planning models that will address not only the supply and distribution of health care resources, but also the demand for health care (i.e., strategies to improve population health and reduce preventable utilization) and the quality of care. While the nature of the planning undertaken may vary by region, every region will be expected to engage in planning activities that address each element of the Triple Aim. They will also be required to identify and develop strategies to address disparities in health and/or health care. In addition, active engagement in regional planning and the support of the regional planning organization will be a significant factor in evaluating applications for waiver funding, including funding for primary care expansion, hospital transition, safety net and vital access providers, capital access, and new medical care models.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples .

The waiver amendment's goal is to transform New York State's health care delivery system into one that is integrated and provides access to high-quality, coordinated care for every New Yorker. The delivery system will work with local health departments, consumers, business, payers and others, to promote health and treat illness. It will provide care in the most appropriate setting and amounts, consistent with evidence-based practices. It will not provide unnecessary care in order to maximize reimbursement or due to failures in communication among providers. Access to care, outcomes, and health status will not vary based on race, ethnicity, or socioeconomic status.

At the end of the waiver period New York will have a robust, statewide system of regional planning that will be completely aligned with the Triple Aim.



Regional Health Planning (continued)

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

The Department of Health expects to award contracts through a request for grant applications process to qualified organizations that meet the technical specifications as outlined in the application. In the case of regional planning, DOH may need to foster development of qualified organizations as they are discrete and organic to each region.

Each applicant must fulfill numerous requirements to receive funding including describing the background, experience, and structure (including representation of multiple stakeholders and collaborative relationships) that qualify it as a bidder, and if applicable, its subcontractor(s), to undertake the functions and activities required. Additionally, there will be outcome based and quality metrics associated with each application. All bidders must detail their proposed approach and provide a completed work plan outlining how they will address the program requirements and detail when activities will be completed. Successful applicants will be required to submit quarterly reports that describe grant activities and evidence that they are meeting all requirements at specified timeframes. Providers that fail to meet agreed upon deliverable will jeopardize future funding as the State can exercise its option to cancel the contract due to unsatisfactory performance.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

As stated above, the Department of Health will award contracts through a request for grant applications process to qualified organizations that meet the technical specifications as outlined in the application. Each applicant must fulfill numerous requirements to receive funding including describing the background, experience, and structure that qualify them as bidders, and if applicable, its subcontractor(s), to undertake the functions and activities required. Also, all bidders must detail their proposed approach and provide a completed work plan outlining how they will address all the program requirements.

The contracts will be for a maximum contract period of five years, subject to the sole option of the State and satisfactory performance and availability of funds. Payments to contractors will be made based on the work plan and deliverables.



Regional Health Planning (continued)

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

The funds are required to assist communities in determining how to best to develop new systems of care with input from all stakeholders, to reduce unnecessary utilization, eliminate disparities and improve population health. We are not aware of other funding for this purpose, but we will coordinate with existing funding where available.

Regional health planning will reduce Medicaid spending by bringing together consumers, providers, purchasers of health care, and public health officials, among others, to:

- Align payment incentives to promote better outcomes and reduce unnecessary or preventable utilization;
- Facilitate transitions in care and care coordination;
- Close important health and health care disparities that can lead to preventable utilization and poor outcomes; and
- Develop collaborative strategies to engage consumers not only in their own care and health promotion, but in the future of their delivery system and the health status of their communities.



MRT and Waiver Evaluation Program

Question #1: What are the core problems in health care delivery this program plans to address? As part of this answer please describe the "current state" the program will attempt to transform/improve.

Current state is a multi-faceted care system with multiple measures that are not well aligned or integrated in a manner that facilitates comprehensive evaluation of the care system in light of the goals of the Triple Aim.

The resources requested through this waiver will support both external and internal evaluations that measure programmatic effectiveness and efficiency and provide critical information needed to create an evidence base for new and evolving programs.

Question #2: How will this program help achieve the Triple Aim in New York?

The waiver amendment seeks to demonstrate a comprehensive approach to innovation and includes a number of reporting and evaluation requirements designed to inform the federal government and the state of the progress achieved, challenges encountered and lessons learned as the demonstration is implemented. Effective implementation and identification of lessons learned requires that a portion of the MRT savings generated as a result of the action plan be dedicated to a rigorous and thorough evaluation of ongoing as well as new MRT initiatives.

Question #3: What will the state's health care delivery system look like after this program is implemented (post waiver period)? Provide the vision for the future with specific examples (i.e. Brooklyn will have a stable health care delivery system which provides high quality service for the first time in decades).

In the future New York State will have in place, supported by this waiver, a comprehensive system of performance measurement that will measure performance across the entire state's health care system. These measures will build on existing Medicaid and managed care metrics (HEDIS®, CAHPS®, hospital and provider level metrics and more) and be complemented by a series of measures that address and evaluate new initiatives that center on long term care, behavioral health and population health. New York will align efficiency measures such as preventable hospitalizations and emergency room visits both of which are key indicators of success for many MRT initiatives, including Health Homes, Patient-Centered Medical Homes and care management for all. A novel set of population health core measures will align with New York's public health goals with quality across all payers. The system of the future will be performance based and more efficient than it is today.



MRT and Waiver Evaluation Program (continued)

Question #4: How will the state ensure that the goals of the program are achieved? Specifically, what consequences will exist for providers that receive funds and fail to achieve agreed upon benchmarks/metrics?

Programmatic goals and objectives can only be realized through carefully monitoring and evaluation that seeks to measure and inform future program and policy. To assure that the proposed programs meet the goals of the Triple Aim New York State Department of Health (NYSDOH) is creating comprehensive systems to measure, evaluate, track and report on metrics for each of the MRT initiatives. All initiatives will undergo rigorous evaluation to assure that unique goals and objectives are achieved and well as overarching or cross-cutting goals such as access for disenfranchised populations, reduction of health disparities, reduction of preventable events, promotion of a culture of quality and operation of an efficient and effective health care system. Evaluation activities will follow two simultaneous tracks – evaluations of individual initiatives and evaluation of the broader health care system to assure achievement of the three goals as enumerated by the Triple Aim.

Question #5: How will funds "flow" to approved projects? Describe the application process as well as what plans currently exist for how funds will be distributed throughout the waiver period.

Funding of external evaluation partners will be done through a competitive Request for Proposal (RFP) process. It is expected that the NYSDOH will partner with the most advanced academic and health evaluation institutions, foundations, and associations from across the nation, as the waiver evaluation process will be objective, comprehensive, and will inform health systems change across the country

Question #6: Why are these funds necessary? Why can't the state fund these efforts with other state or federal funds? Describe how waiver funds for this program will relate to other federal funding opportunities.

The multiple and inter-related MRT initiatives represent new innovations heretofore untested and for which evaluation funding (both external and internal) is not available. New York will assure that where possible, when economies of scale can be achieved, coordination and integration of multiple evaluation projects will occur utilizing existing state and/or federal funds. The need for and import of evaluation was noted by several entities commenting on the draft waiver including the Hospital Association of New York State (HANYS) and the Conference of Local Mental Hygiene Directors, Inc. HANYS recommended that the standards used to evaluate waiver programs be: transparent; developed with stakeholder input; agreed upon in advance; grounded in evidence-based science, reliable; clearly defined; reproducible; standardized and useful.