

New York State SIM Year 2 Operational Plan

New York State Department of Health

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A) PROJECT SUMMARY

A1. Executive Summary

New York's State Innovation Model testing grant (SIM) seeks to transform primary care delivery and payment models across the State, eventually reaching 80 percent of New York's primary care providers, payers, and patients. The SIM is a part of New York's larger State Health Innovation Plan (SHIP)¹, which is driving evolution of health delivery and payment systems through numerous initiatives in support of the Triple Aim - improving the patient experience of care (including quality and satisfaction), improving the health of populations, and promoting more efficient use of health care resources. Under this coordinated framework, the State is simultaneously implementing SIM, the Transforming Clinical Practice Initiative (TCPI), the Medicaid Delivery System Reform Incentive Program (DSRIP) to redefine the model of care delivery and payment for the state's more than 6 million Medicaid beneficiaries, the New York State of Health, New York's successful health insurance exchange which has enrolled over 2.1 million residents to date², and the State's Prevention Agenda, a statewide vision for public/population health. In addition, numerous regional initiatives are ongoing such as the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration and the Comprehensive

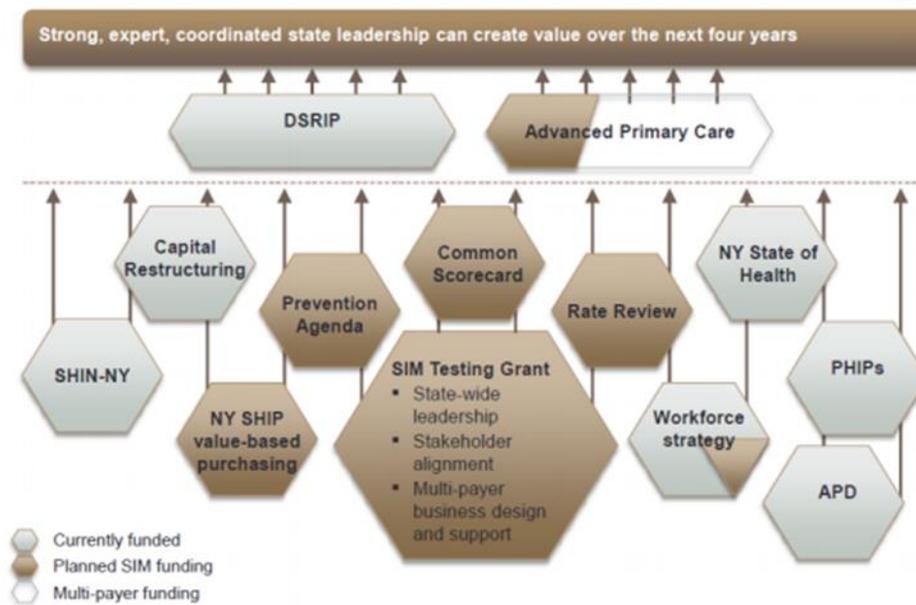
¹ New York State Health Innovation Plan (SHIP) and State Innovation Model (SIM)- https://www.health.ny.gov/technology/innovation_plan_initiative/
Delivery System Reform Incentive Payment (DSRIP) program- http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/;
NYS Prevention Agenda- https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/;
New York State of Health (NYSOH)- <https://nystateofhealth.ny.gov/>;
Population Health Improvement Program (PHIP)- https://www.health.ny.gov/community/programs/population_health_improvement/

² https://www.health.ny.gov/press/releases/2015/2015-07-29_nysoh_enrollment_report.htm

Primary Care Initiative (CPCi) both of which will be aligned with SIM under the overarching SHIP umbrella.

FIGURE 1: THE SIM GRANT COUPLED WITH OTHER INITIATIVES

THE SIM GRANT WILL SPUR INNOVATION AND CATALYZE CHANGE



Overarching SIM goals include the following:

Improving Health

- Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement

Improving Quality of Care and Consumer Experience

- Achieve high standards for quality of care and consumer experience, including at least a 20 percent reduction in avoidable hospital admissions and readmissions

Spending Health Care Dollars Efficiently

- Assure that 80 percent of the primary care delivered in New York State is “Advanced” and utilizes payment models that promote and incent high value care.

Central to the State’s SIM is development, implementation and testing of an advanced primary care model. The model is premised on successful models that have been employed during recent years in both New York and nationally, including the Patient-Centered Medical Home (PCMH), the Comprehensive Primary Care initiative (CPCi) and the Multi-payer Advanced Primary Care Practice (MAP-CP) demonstration. Based on lessons learned to date, the Advanced Primary Care (APC) model seeks to assure that New Yorkers are able to access better integrated primary care supported by a multi-payer value-based payment model, a skilled workforce evolved to meet the needs of a transformed delivery system, and a common set of quality and utilization measures determined to be of mutual import to payers, providers and consumers.

New York’s SIM is premised on the following initiatives to support of an evolved care delivery and payment system that promotes and incents high quality, efficiently delivered care:

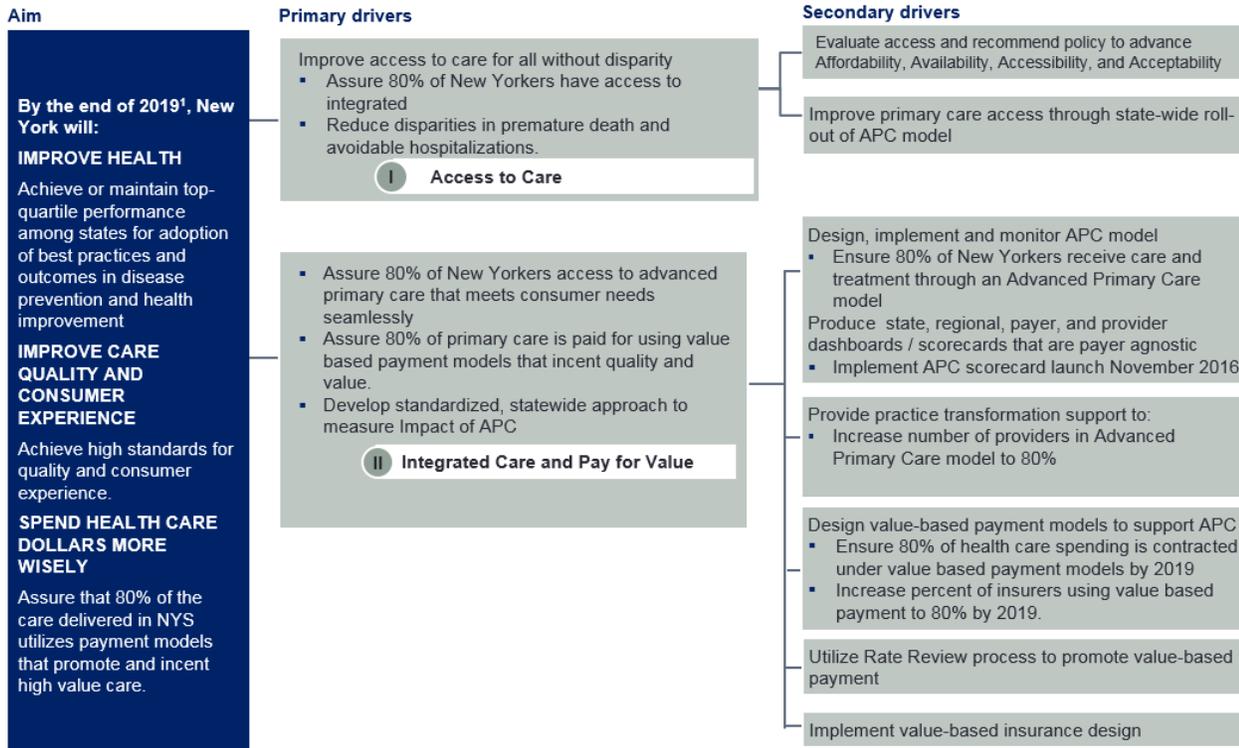
1. Support of regionally-based primary care practice transformation entities to assist practices across New York to adopt and use the APC model;
2. Creation of an aligned payment model agreed to by all payers that incents an integrated primary care model inclusive of care management and subject to outcome based payments within defined quality standards;
3. Creation and adoption of a core set of quality measures (a common scorecard) shared across multiple payers and providers;

4. Continued implementation of the State-supported All Payer Database (APD) and Statewide Health Information Network of New York (SHIN-NY);
5. Integration of clinical services provided by APC practices with community-based population health services to promote population health;
6. Continued implementation and local support of New York State's Prevention Agenda 2012-2018;
7. Evolution of New York's primary care workforce through innovations in professional education and training including rural residency programs and novel initiatives to retain physicians trained in New York State; and
8. Support of an independent evaluator to guide and refine processes and activities throughout the life of the grant.

A2. Driver Diagrams

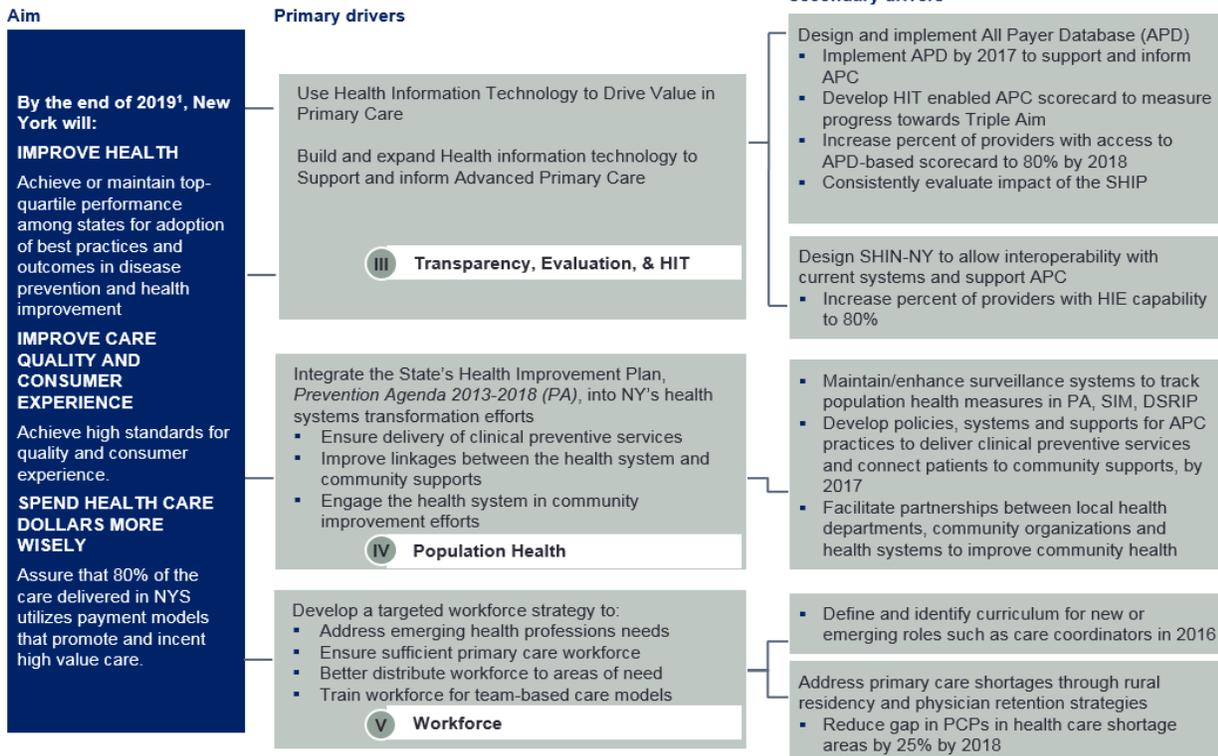
FIGURE 2: DRIVER DIAGRAMS

SHIP Drivers diagram (1/2)



¹ Unless otherwise specified

SHIP Drivers diagram (2/2)



¹ Unless otherwise specified

A3. Core Progress Metrics and Accountability Targets

Achievement of core goals and objectives as measured by drivers are as follows:

Core Drivers	2016 Accountability Targets
<p>Improve Access to Quality Care for all without disparity</p> <ul style="list-style-type: none"> • Assure 80% of New Yorkers have access to integrated advanced primary care • Promote improvement in core measures related to prevention, chronic disease, patient access and appropriate use of services 	<p>Projected percent of beneficiaries impacted:</p> <ul style="list-style-type: none"> • Baseline established for APC Common Measure set Q3 2016 • Initial practice assessment tool deployed with information on number of patients Q3 2016 • Practice enrollment in APC and reporting on number of individuals in receipt of care initiated Q4 2016 • SIM will establish mechanisms for determining the number of beneficiaries impacted by practice. • Goal: 1,659,394 individuals cared for by APC practices by Q1 2017
<p>Promote Integrated Care and Payment for Value</p> <ul style="list-style-type: none"> • Assure 80% of primary care is paid for using value based payment models that incent quality and value. • Increase number of providers in Advanced Primary Care model to 80% • Develop standardized, statewide approach to measure impact of APC 	<ul style="list-style-type: none"> • DFS request for information (Q1 2016) to establish baseline and assess payer willingness to participate in APC • NYS SIM will determine the number of payers participating in APC annually beginning Q4 2016 • Goal: 8 payers by Q1 2017
<p>Use Health Information Technology to drive value in primary care</p> <ul style="list-style-type: none"> • Build and expand state-supported health information technology to support and inform Advanced Primary Care 	<p><u>SHIN-NY</u>: Statewide patient lookup (connecting RHIOs to each other). As of December 2015, 8 RHIOs are connected and sharing data and there is a concentrated efforts on adoption by individual providers.</p> <p><u>APD</u>: Since January 2015, 23 New York State of Health Exchange Qualified Health Plans</p>

	<p>(QHPs) have been submitting data to the Encounter Intake System.</p> <ul style="list-style-type: none"> • Medicaid managed care plans began submitting data in September 2015. • Collection of production data from large commercial payers will begin in late 2016. • Goal: Full Implementation 2018
<p>Promote and ensure population health through:</p> <ul style="list-style-type: none"> • Delivery of clinical preventive services • Improved linkages between the health system and community supports • Engaging the health system in community improvement efforts 	<ul style="list-style-type: none"> • Progress on the Prevention Agenda is tracked using a dashboard available on the Department’s public website³ • See <i>Appendix B</i> - Population Health • Practices Transformation (PT) entities will help primary care practices achieve many of the Prevention Agenda goals by achieving APC capabilities to deliver clinical preventive services and appropriate chronic care management; • PT entities will also assist primary care practices to identify and support activities of the local county Prevention Agenda coalition to achieve locally selected goals.
<p>Develop a targeted workforce strategy to:</p> <ul style="list-style-type: none"> • Address emerging health professions needs • Ensure sufficient primary care workforce • Better distribute the healthcare workforce to areas of need • Train workforce for team-based care models 	<ul style="list-style-type: none"> • Develop recommendations for core competencies and associated curriculum for care managers – Draft recommendations Q1 2016 • Issue RFP to develop accredited new or restructured GME programs serving rural communities in New York State. The beginning date for the contracts will be April 1, 2016. • Increase retention of physicians trained in NYS. Award grant Q3 2016 with program implementation Q1 2017.

³ https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard

2016 as an initial implementation year is likely to show slow up-take of APC and use of the Common Scorecard metrics as providers are first offered practice transformation assistance (beginning in Q2 2016) and as payers begin to implement APC value based payment strategies (Q1 2017 based on 2016 budgets and rate submissions). Initial baseline statistics and targets for 2016 may be found in *Appendix I: Operational Measures for 2016*.

Measures at the practice level will be collected and reported through the APC Scorecard. The APC Common Scorecard, which is designed to reflect the performance of a primary care practice, is expected to measure improvements during the APC journey, and is, in fact, a requirement to progress along the three APC Gates. As 2016 is an implementation year there may not be significant improvements in common scorecard measures. By 2017, however, improvements are expected. (Please see Figure 3 and Figure 4 below for Scorecard and timeline.)

In addition to providing information to practices and payers, it is anticipated that the APC scorecard will be used to evaluate systemic performance through aggregated measures at the state and regional level over time. Below is a timeline for development of the APC scorecard followed by a draft set of measures agreed to by multiple external constituencies. Full implementation of the scorecard is predicated on a fully functional All Payer Database (APD). Given that New York's APD will not achieve full functionality until late 2017 (see Figure 12), an interim solution has been developed that will begin to collect a subset of measures (highlighted in grey below) beginning Q4 2016.

FIGURE 3: APC SCORECARD

Draft high-level 12-month plan

PRELIMINARY

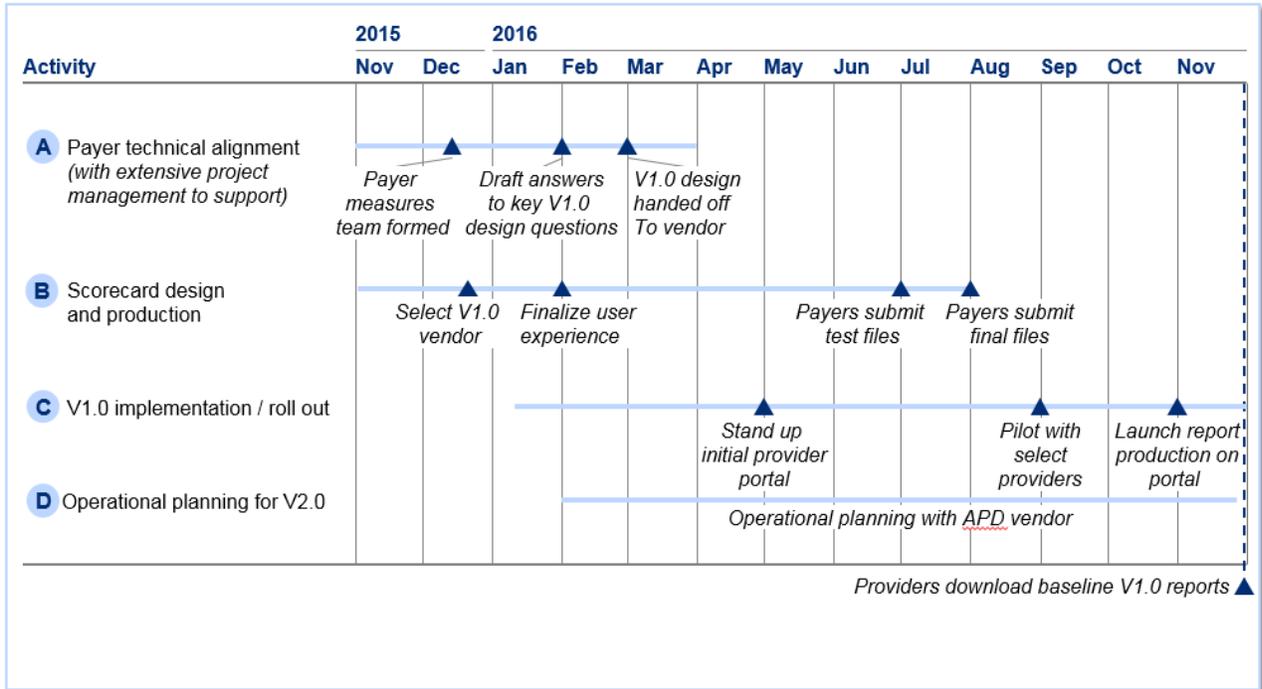


FIGURE 4: APC CORE MEASURES

20 core measures are proposed for inclusion in the APC Common Measure Set; 9-12 of the measures are targeted for V1.0

Claims-only is possible
 Candidate V1.0 measures

Categories	Measures	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	✓	✓	
	2 Chlamydia Screening	✓	✓	
	3 Influenza Immunization - all ages	✓	✓	✓
	4 Childhood Immunization (status)	✓	✓	
	5 Fluoride Varnish Application	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	✓	✓	
	7 Controlling High Blood Pressure	✓	✓	
	8 Diabetes A1C Poor Control	✓	✓	
	9 Medication Management for People with Asthma	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	✓	✓	
BH/Sub-stance abuse	11 Depression screening and management	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓		
Patient reported	13 Record Advance Directives for 65 and older	✓	✓	
	14 CAHPS Access to Care, Getting Care Quickly			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
	17 Hospitalization	✓		
	18 Readmission	✓		
	19 Emergency Dept. Utilization	✓		
Cost	20 Total Cost Per Member Per Month	✓		

To track physician participation in numerous practice transformation activities (SIM, Transforming Clinical Practice Initiative and DSRIP) the State is creating a consolidated data system to account for practice and provider participation, number of beneficiaries impacted and other information such as the number of providers that are HIE enabled throughout New York. This information will be mapped by Visio to track, over the course of the project, provider addresses/locations by region, advancement through APC Gates, provider NPI and source of transformation assistance.

Master Timeline with Detail

SIM INITIATIVE COMPONENT	YEAR 1 -2016	YEAR 2- 2017	YEAR 3 - 2018	DETAIL
Overarching Governance, Coordination and Communication	Staffing fully in place; consultants secured as needed; Communications initiated	Contract management staffing; reduced reliance on external consultants	Heavy emphasis on evaluation; beginning to evolve to sustainable care delivery model	Strong and consistent leadership is key to achievement of core goals and objectives.
ACCESS TO QUALITY CARE				
Improve access to quality care for all without disparity	Targeted task forces convened to address topic-specific concerns such as cultural competence, literacy, geographic access to care and needs of special populations; Initial data collection using interim APC Core data Set	Begin to measure Access as defined by APC core measures: CAHPS Access to Care, Getting Care Quickly Develop key policy recommendations for consideration by the Innovation Council Evolution to data collection use NYS-funded APD	Develop key policy recommendations for consideration by the Innovation Council Review of first full year of implementation to evaluate progress on APC measures relative to baseline and national or state benchmarks (TBD)	Key areas of access will be addressed by topic-specific experts for the purpose of developing recommendations for consideration by the Innovation Council.
INTEGRATED CARE AND PAY FOR VALUE				
Practice Transformation To Achieve Advanced Primary Care	Issue Procurement to Contract with Transformation Vendors	Full implementation in all regions	Continued implementation with first, most advanced practices graduating to Gate 3 – fully payer funded.	Overarching goal of NYS SIM is to evolve all primary care to be consistent with APC standards and guidelines.
APC Payer Engagement	Secure payer commitment to support APC Q1	Initiate comprehensive payer engagement	Continue to evaluate participation; begin to evaluate impact on TCC	2016 rate review and budgeting to support 2017 payer support of APC

APC Metrics/Scorecard	Finalization of metrics and development of interim (pre APD) solution	APD becomes operational and practices transition phase out interim solution	Fully operational APD and evolved SHIN-NY used to provide provider-specific metrics.	Claims-based information together with population health metrics inform practices, payers and government (NYS and CMMI)
TRANSPARENCY EVALUATION AND HIT				
Health Information Technology	Interim data collection solution introduced	APD becomes operational; SHIN-NY continues to evolve	APD and SHIN-NY fully operational	HIT is foundational to APC but is evolving. As a result an interim solution devised to assure smooth implementation of APC model.
POPULATION HEALTH				
	<p>Complete fact finding project, issue RFP to meet needs identified in key informant interviews, contract with entities/individuals</p> <p>Continue to integrate the Prevention Agenda into NY's health systems transformation efforts</p>	Ongoing clinical-population health interactions evolving from CDC bucket one to bucket three	Ongoing clinical-population health interactions evolving from CDC bucket one to bucket three	The Department's Office of Public Health's activities, programs, and internal and external funding align with and support achievement of the Prevention Agenda goals, and are aligned with the SIM population health goals.
WORKFORCE				
	Rural residency and physician retention initiatives funded; care coordination	Full implementation of workforce initiatives;	Evaluation of work to date and determination of next steps.	Key initiatives to be addressed include: shortage of primary care workers in key geographies; lack of a consistent

	core competencies work initiated	Development of career pathways and stackable credentials to address needs of an evolving workforce		definition for care coordination and lack of a clear path or set of policies to evolve the health workforce to best support evolving care delivery models.
EVALUATION	Contractor engaged and methodology defined.	Date collection initiated.	First set of analytics complete	Transformation is anticipated to take 1-3 years (depending on starting point); achievement of goals and objectives not anticipated until test year 3.

A5. Budget Summary Table Year 2

Component – Project	Description	Expected Expenditures	Primary Driver	Metric/Goal
1. Overarching Governance, Coordination and Communication	Assure SIM goals and objectives are met	\$1,350,845	Overarching governance, clear communications and expectations.	Efficient and effective goal attainment
2. Access	Assuring all New Yorkers access to quality care without disparity	\$300,845	Access to Care Improve access to quality care for all without disparity	Improve primary care quality and access to care through state-wide rollout of APC.
3. Practice Transformation To Achieve Advanced Primary Care	Fund PT entities to work with practices to evolve to APC model and an independent auditor to assess practice progress according to	\$12,850,845	Integrated Care and Pay for Value Increase number of providers in any level of Advanced Primary Care model to 90% 75% of PCPs in shared risk arrangement	80% of all Primary care providers practicing consistent with APC model in five years.

	gates and milestones.			
4. APC Payer/Provider Engagement	Engage payers to ensure alignment and support of the APC model. Create clear and consistent communication strategy to ensure alignment and coordination between SIM, TCPI and DSRIP.	\$1,050,845	Integrated Care and Pay for Value Pay for value, not volume Ensure 80% of health care spending is contracted under value based payment models Increase percent of insurers using value based payment to 80%	80% of PCPs in shared risk arrangement in 5 years
5. APC Metrics/Scorecard	Support socialization and implementation of a common measure set for all participating APC providers.	\$900,845	Integrated Care and Pay for Value Develop standardized, statewide approach to measurement	Interim data solution implemented in advance of fully functional and integrated APD and SHIN-NY
6. Health Information Technology	Secure full development and implementation of the APD and support SHIN-NY ongoing development to inform practices, providers, payers and the State.	\$500,845	Transparency, Evaluation and HIT. Build and expand Health information technology Increase percent of providers with HIE capability and/or APD access to 80% Increase percent of providers e-prescribing to 80% by 2019	Make health care cost and quality transparent Engage 20% of New Yorkers in using consumer portal
7. Population Health	Promotion of NYS prevention agenda goals and objectives through enhanced integration of clinical and	\$1,400,844	Population Health Promote population health	Continue implementation and local support of Prevention Agenda (PA) Maintain/enhance surveillance systems to track

	population health providers.			population health measures in PA, SIM, DSRIP Develop supports for APC practices to deliver clinical preventive services and connect patients to community supports Maintain/enhance surveillance systems to track population health measures in PA, SIM, DSRIP
8. Workforce	Assuring an appropriately trained and adequate workforce to meeting and support evolving care delivery systems and models.	\$1,850,845	Workforce. Develop a targeted workforce strategy	Increase PCPs in health care shortage areas by 25% by 2017
9. Evaluation	Secure contract for initiative evaluation inclusive of rapid cycle feedback.	\$800,485	Assure key goals and objectives are met in an effective and efficient manner	

Explanation of Adjustments to Budget from Previous Submissions:

The Innovation Center has adjusted the Year 2 budget from prior projections. These adjustments are intended to optimize the SIM grant’s return on investment by allocating scarce resources strategically. Increases to salary, fringe, equipment and indirect are due to the anticipated hiring of additional SIM staff to assist in managing the Practice Transformation, evaluation, workforce and independent auditor contracts which constitute the majority of SIM

funding across grant years. Funds to accommodate these budget changes have come from budget lines that were determined to not be needed (such as curriculum development). There are also anticipated savings for 2016 due to the incremental roll out of APC by region in Year 2. Regions will be activated one at a time premised on payer participation. There will also be a ramp up in terms of payments dispersed to PT entities as practices evolve and make the necessary changes to achieve Gates which will in turn trigger payments to the PT entities. We anticipate that most of the payments for PT will take place during Year 3 as practices pass Gates and milestone/incentive payments are made. The list below summarizes the changes as presented in the table above (numbers correspond to the table above):

1. **Governance:** Hiring six additional SIM staff members over the coming year (SIM Deputy Director, SIM project Manager/Policy Analyst, three contract managers, and an OMH liaison) will require the purchase of computers. At \$1000 per unit, we anticipate \$6,000 in equipment costs in 2016. In-kind support is being provided by DFS staff.
3. **Practice Transformation:** The Innovation Center anticipates that the Year 2 (2016) budget will yield substantial savings over previous estimates (and 2017 will increase). Whereas a statewide practice transformation roll out had previously been envisioned, a more targeted, regional approach is now planned to ensure sufficient payer engagement in regions throughout the State. Additionally, with the PT vendors beginning their work in July 2016, there will be an abbreviated timeline. As a result, practice transformation funding for 2016 is reduced and anticipated 2017 needs will be increased to ensure statewide engagement of practices.

The addition of an **independent entity** to assess practices and transformation vendor accuracy with respect to achievement of Gates and milestones for purposes of reimbursement was recommended and requested by the payer community in New York State. Accordingly, funding is requested to support such an entity and a procurement is in development. Funds to accommodate these budget changes have come from a reduction of the 2016 Practice Transformation funds within the contractual line. It is anticipated that this independent entity will be necessary for a time-limited period until more robust data (from the APD and an evolved SHIN-NY) are available to support and inform outcome based payment models.

4. **APC Payer/Provider Engagement:** Given the numerous initiatives occurring in New York simultaneously that focus on practice transformation and the need to ensure alignment and coordination, a focused, strategic and clear communications strategy targeted to practices and providers has been identified as essential. The communications contractor will specialize in messaging to various audiences to maximize effectiveness. Informational resources that are simple, informative, and attractive that ensure effective communications to targeted audiences will be developed for broad dissemination. All materials will be developed in coordination with appropriate TCPI and DSRIP staff to ensure accuracy. This contractor's role is unique from the Northeast Business Group on Health's (NEBGH) role, as NEBGH is contracted to engage payers throughout the state, particularly large, self-insured entities to ensure their support of the APC model – not necessarily to ensure clarity of message goal and objective of the numerous ongoing health innovation initiatives in New York. The tasks and deliverables for each contractor are distinct.

5. **APC Scorecard:** The New York State APD will not be fully functional at the rollout of the APC model. Accordingly, an interim solution to collect data to share with practices has been planned. The contracted vendor (in discussions now) will collect claims data about practices from various sources to inform SIM decisions and preliminary scorecards (claims only measures) until the APD begins collecting commercial data.
6. **HIT:** New York State has made sizable investments in statewide HIT initiatives and will continue to support initiatives such as the SHIN-NY (\$55 million in year two) and all payer database (\$15 million in year two) over the life of the SIM grant and beyond. SIM funds will be used to pay for consultant services that will advise leadership regarding long-term policy decisions, infrastructure, and interoperability. SIM funding supports expert consultants charged with providing strategic advice on how best to structure health information exchange activities in New York State to support goals of integrated care delivery, health information exchange and health information transparency efforts. Specifically, the funded consultants provide strategic advice on: how regulatory activity can support EHR system adoption and health information exchange; how NYSDOH supported HIE activities should align with national standards and activities such as the Electronic Health Record Incentive Program and EHR certification programs; and provide recommendations on how HIE activities can support of the state health innovation plan, the Triple Aim, and advanced primary care providers. These needs were identified subsequent to the original grant submission.

7. **Workforce:** In the initial application rural residency and physician retention procurements were combined in order to meet the required page limit. As a result of ongoing discussions with stakeholders it was determined that the funding necessary to support creation of a rural residency program is \$1 million annually. A first draft of the rural residency RFP was finished in November and the physician retention RFP is in its initial stages subject to further external stakeholder input.

A second change requested is allocation of funding (\$250,000) to support the University at Albany School of Public Health Center for Health Care Workforce Studies (Center). Priority areas identified by the Workforce Workgroup were determined to be well aligned with the skills and competencies of the Center which has the substantive understanding of New York State physician workforce issues and extensive expertise in health workforce data collection. The Center is shared with working with external stakeholders to conduct analytics and prepare policy briefs for SIM staff regarding care coordination, health work supply and projected needs, career ladders and evolving the health delivery workforce.

8. **Evaluation:** SIM staff, together with CMMI, have worked to develop a state evaluation RFP. This RFP is in final review and will be issued in Year 2. The original plan included measure development and scope in addition to evaluation activities that overlap with federal evaluation activities. These activities have been removed from scope. SIM staff are confident the funding thresholds proposed a reasonable and appropriate given the reduction in scope.

Activities related to PT **curriculum adoption** as originally envisioned have been fulfilled by other federal and state initiatives such as TCPI, CPCI, and DSRIP. Clinical advisor input has

been taken on by in-kind New York State Department of Health physicians who were heavily involved in SIM, TCPI, and other reform activities within the New York State Department of Health. Accordingly, contractual funds are no longer needed.

For a complete line item break down, please see *Appendix G* for the 2016 Budget Narrative.

B) DETAILED SIM OPERATIONAL PLAN

Guiding Principles

New York's SIM goals involve widespread systems change at every level of health care delivery. This requires a broad commitment to change at every point of contact including state government, clinical providers, workforce institutions, payers (commercial, self-insured and public) and at the heart of SIM, consumers. SIM resources will be used to fund an external evaluation contractor and will use traditional project management tools to ensure efficiency, goal attainment and course correction as needed. New York's SIM is premised on the following:

1. Strong project management

New York has hired a senior project manager for SIM along with numerous seasoned staff to lead this complex, high stake project. We have the tools to develop solid project planning and management systems, track and communicate progress, assure early identification of issues and barriers, and work proactively toward effective solutions. For SIM activities, New York has implemented biweekly meetings of the SIM Operations Team as the platform for early identification of emerging risks and signal implementation of necessary mitigation strategies.

2. Consistent communications

With SIM support, we will secure an expert in communications to assure the conveyance of consistent and reliable information both internally as well as with our disparate stakeholders.

Regular communications with CMMI and New York's project lead will continue to identify any emerging risks and discuss any needed assistance for mitigation.

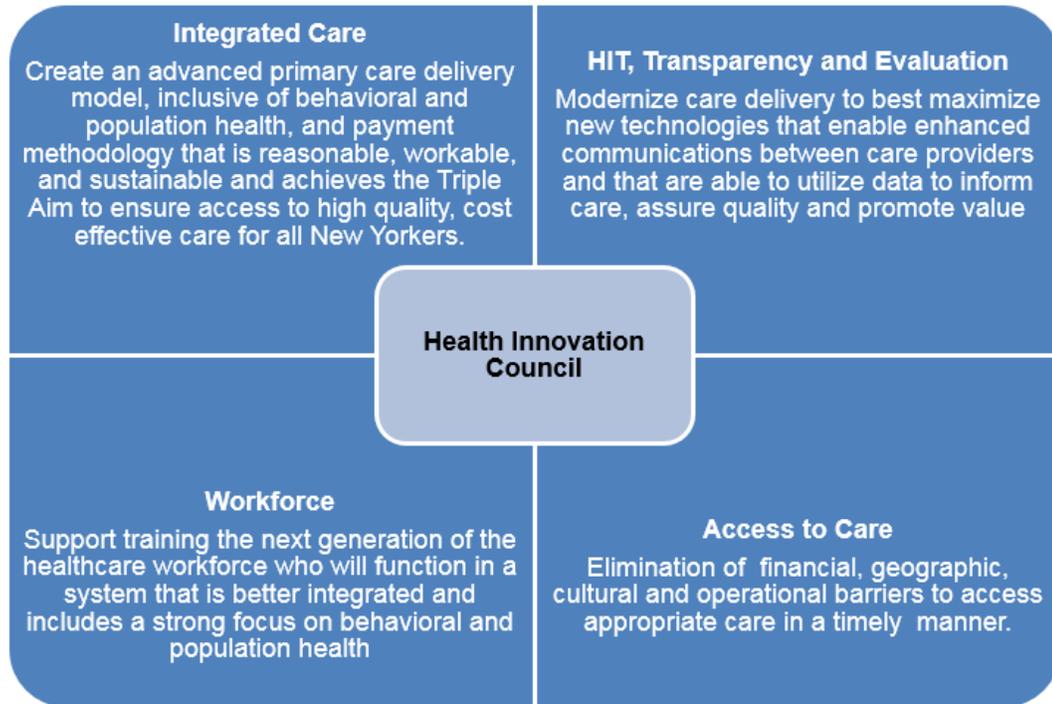
3. Involvement of stakeholders at every level

As reflected in our SIM Operational Plan, New York has committed to extensive stakeholder engagement that spans across both multi-sector workgroups, targeted subgroups and, as needed, one-on-one meetings to socialize concepts, secure input, and assure engagement. Multiple workgroups have been convened to engage expert input on a wide array of issues (see Figure 5). Participants on each workgroup are broadly representative and include payers, providers and consumers. Workgroups that are regularly convened include: Integrated Care and Pay for Value (over 40 members representative of health care providers, physicians, insurers and consumers), Transparency, Evaluation and HIT (representative of all sectors of the health delivery system from individual providers to home care to large hospital systems with a focus on HIT expertise), Workforce (with representative from educational institutions, health policy organizations, health professions and labor unions), a Multi-payer subgroup to address SIM APC initiatives from the plan or payer perspective, and a Purchaser Advisory Council convened to solicit guidance and input from employers, particularly larger employers who self-insure. The Northeast Business Group on Health has assisted New York State's SIM by convening a multi-payer workgroup that is inclusive of all commercial payers through New York State. Monthly meetings have been convened to discuss and address the role of payers in supporting New York's SIM model. In addition, New York State SIM staff (DOH and DFS) have engaged payers in one-on-one meetings for more detailed discussions of unique or individual payer-sponsored primary care initiatives and alternative payment models. As an example, slides from the most recent multi payer meeting are included as *Appendix K*. Detail on many of these

workgroups, including slide sets and other materials, can be found on the NYSDOH website:
https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm

FIGURE 5: SHIP GOVERNANCE STRUCTURE

SHIP Governance Structure



As New York continues to refine, implement, and assess the various initiatives that together comprise SIM's implementation, we seek continuous feedback and opportunities to improve quality and access, and reduce costs at every level. Delivery system leaders, hospitals, clinicians, payers, and consumers are afforded multiple avenues to participate and provide input into the model.

4. Commitment to access

New York has a deep commitment to assuring access to care and reducing health disparities. We do this through our active partnering with communities to develop positive, proactive solutions in order to overcome barriers to access. Impact on access will be considered as alternatives or changes in strategy, focus, resource allocation, or other aspects of our model are examined or implemented. Explicit efforts are built into New York's SIM activities such as the Access to Care Workgroup initiatives, designed to assure access and measures of access, which have been incorporated as part of the APC Common Scorecard.

5. Responsive to local needs

Ranging from the five boroughs of New York City, to the wilderness of the Adirondacks, New York is a diverse state. Creation, implementation, and evaluation of SIM initiatives, particularly APC, will take place regionally and will explicitly consider prior transformation work, resource needs and opportunities that are region-specific. Providers and health systems' unique challenges and concerns are incorporated in the efforts of the Innovation Center and the Advanced Primary Care model to propagate and share best practices, peer to peer.

6. Transparency

New York will continue to use the Health Department's website to facilitate transparency in our health transformation efforts and we will continue to secure external stakeholder input on tools and information that may be used to ensure broad sharing of relevant information with all stakeholders.

7. Data-driven decision-making

SIM investments, together with ongoing New York State efforts like the SHIN-NY and the APD, will allow the State to provide detailed reporting on health outcomes at multiple levels

and reflect upon the strengths and weaknesses of the system to identify successes and focus on needed improvements. These will serve as platforms to inform health innovation from the multiple perspectives of cost, quality, and access.

8. Implementation of evidence-based best practices

New York has a long history of promoting evidence-based decision-making. SIM investments in the Innovation Center and other SIM project areas that will facilitate our ability to broaden efforts across the delivery system. This support will allow New York to identify evidence-based practices and scale or adapt them for implementation.

9. Risk Identification and Mitigation Planning

The Innovation Center conducted a thorough risk analysis to gauge the likely success of the SIM grant over its 48-month award period. The mechanics of that assessment included risk identification, categorization, and management planning

Identification began with dedicated risk management meetings between the Innovation Center staff, workgroup chairs, and stakeholders. The Center then quantified the identified risks using the technical assistance tools provided by CMMI. These matrices allowed the Center to categorize risks based on their probability of occurrence in the degree to which, if they occurred, how severely they would impact the SIM grant's performance. The Center staff then further refined these rankings by assigning high, medium, and low values to each risk based on their probability score. Utilizing these rankings, a management plan for each of the risks was developed. The recommended strategies range from improving effective communication to more targeted, remedies tailored to specific mitigation tactics. Detail on risks and mitigation strategies may be found in *Appendix H*.

As part of the Innovation Center’s project management approach, risks will be continually monitored and assessed utilizing the tools and processes described above. An internal database has been developed with a tracking matrix to follow risks once identified. It is incumbent on every member of the SIM team to draw attention to perceived risks for collective assessment. Additionally, at each project meeting, time will be dedicated to identifying new or changed risks and, as needed, mitigation planning. (See *Appendix H: Risk Mitigation Matrix.*)

B1. Narrative Summary by Component/Project Area

New York’s SIM initiative is being implemented through a coordinated set of task-specific workgroups. These workgroups are organized under the direction of overarching Innovation Council charged with guiding the numerous intersecting health payment and delivery system initiatives under way in New York. Information for each workgroup is provided below:

1. OVERARCHING GOVERNANCE, COORDINATION AND COMMUNICATION

a) Narrative Summary

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

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

Reporting to the Health Innovation Council are three topic-specific workgroups outlined below. To ensure further coordination across workgroups and the Council, several Council members also serve on the topic-specific workgroups.

2. INTEGRATED CARE WORKGROUP

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

Charge:

- Create a vision for Advanced Primary Care (APC) that coordinates care across specialties and care settings, improves consumer and provider experience, improves quality, and reduces costs.
- Catalyze multi-payer (including commercial, Medicaid, and Medicare) investments in primary care practices to ensure aligned incentives and supports necessary to achieve the Triple Aim.
- Align measurement to ensure consistency and support for providers and payers to focus on a key set of meaningful measures.
- Provide expert guidance on practice transformation, model design elements, and payment strategies.

Composition: The Integrated Care Workgroup is co-chaired by a state representative from the Department of Health and the Department of Financial Services, as well as an external co-chair who has a breadth of experience in multi-payer initiatives in New York, including CPCi. Given the charge of this workgroup to refine the components of the APC model, this is the largest workgroup with a broad membership list representing payers (including public, private, regional and national health plans), providers (including primary care, specialists, family medicine,

pediatrics, hospitals and health systems), consumer representatives, behavioral health, population health, human service organizations, and others as interested.

Multi-payer alignment will be promoted through ongoing workgroup discussions and deliberations as well as targeted outreach as follows:

- Individual health plan meetings, convened by the New York State Department of Financial Services (DFS), will continue throughout 2016.
- Issuance of a request for information by DFS in December 2015 to secure information from health plans on current primary care value-based initiatives used to establish a common baseline and better understand plan support of the APC model in the future.
- March 2016 – Rate review guidance issued by DFS.
- Spring/Summer 2016 - Health Plan Rate Submissions.
- Fall/Winter 2016/2017 - Payers begin to offer contracts aligned with APC.

3. TRANSPARENCY, EVALUATION, AND HIT WORKGROUP

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

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

- Develop recommendations for the State to move toward a comprehensive health claims and clinical database to improve quality, efficiency and cost of care, and patient satisfaction.

- Design and implement/manage standardized, consistent approaches to measure cost and quality to support evaluation of the Plan's impact on system transformation and Triple Aim goals and objectives.
- Provide expert guidance on an APC scorecard for Triple Aim.

Composition: This workgroup is chaired by leadership in the Department of Health and includes multiple state agency representatives as well as external stakeholders including state legislators, regional health information organizations, payers, providers (practices as well as hospitals and health systems), home care representatives, a county health department, and policy organizations.

4. WORKFORCE WORKGROUP

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

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

- Ensure a sufficient primary care workforce.
- Better distribute primary care workforce to areas of need.
- Make the most effective use of the health care workforce under the new model.
- Improve the supply and effectiveness of behavioral health workforce.

- Train workforce for team-based care.
- Improve health workforce data collection.

Composition: The Workforce Workgroup is comprised of stakeholders representing educational institutions and health systems, as well as small provider groups and union and trade associations. The workgroup has been assembled to address workforce issues that span across not only SIM, but also DSRIP. A Compensation and Benefits Workgroup was convened to identify common data reporting elements for compensation and benefits that would allow aggregation of data to regional levels for collaborative planning and analyses.

5. ADDITIONAL ONGOING STAKEHOLDER ENGAGEMENT

Workgroup participants provide additional means for further stakeholder engagement by sharing updates and APC proposals with their membership – for example, the New York Chapter of the Academy of Physicians serves on multiple workgroups and shares information with its chapter members and also provides opportunities for SIM staff to present to their members on topics as opportunities occur.

Numerous ad hoc one-on-one calls occur with stakeholders as well to troubleshoot certain topics that may come up at workgroup meetings, but, due to time constraints, cannot be addressed in detail at the workgroup meetings.

Stakeholder Engagement Timeline – 2016

<i>Stakeholder Type</i>	<i>Forum</i>	<i>Frequency</i>
All stakeholders – workgroup members and anyone signed up for Listserv	NY SIM Newsletter	At least monthly (or more frequently as materials are posted on SIM website)
Public	NY SIM Website (https://www.health.ny.gov/tech)	As materials are developed/available

	nology/innovation_plan_initiative/)	
Integrated Care Workgroup	Workgroup meetings	Monthly
HIT Workgroup	Workgroup meetings	Quarterly
Workforce Workgroup	Workgroup meetings	Monthly (or less frequently to allow time for topic-specific sub-workgroups to meet and report back to full workgroup)
Payers	1:1 health plan meetings	As needed; at least one per plan
Payers	Payer governance council (once APC is launched a forum for participating payers to work through emerging implementation issues)	TBD
Providers	Continued engagement of provider organizations such as APC, AFP and MSSNY	Ongoing- Representatives of all provider organizations as well as individual providers are included on multiple workgroups; webinars and presentations by SIM staff on an ongoing basis.
Providers	APC Learning Collaboratives	TBD
Employers and benefit consultants	Purchaser Advisory Council meetings	As needed / monthly (hosted by NEBGH)
Regional organizations	Population Health Improvement Program	Participation by SIM team at monthly meetings

Internal Governance

The SIM Innovation Center (“Innovation Center”), located within the New York State Department of Health, serves as the lead organization responsible for implementing the SIM and coordinating the governance process across the state. A multi-agency Health Integration Team ensures coordination across program areas within the NYSDOH and partner agencies.

The Health Integration Team reflects a novel approach to system redesign that brings together staff of the Departments of Health, Financial Services, Civil Service, Mental Health and others as needed. Representatives from these agencies participate in weekly meetings and include individuals who play critical roles in coordinating with the State’s Medicaid program, DSRIP initiative and the Prevention Agenda 2013-2017, the state’s population health

improvement plan. The Health Integration Team membership also includes Department of Health staff who are responsible for the implementation of CDC-funded chronic disease grants, including tobacco control, diabetes, heart disease, obesity prevention and control, and cancer prevention and control. These linkages are essential for success in transforming health and health care across all of New York, including both commercial and public payers.

Personnel:

A listing of key staff is included in the Appendix. SIM-funded staff and their duties are included in *Appendix G*, the New York State SIM Budget Narrative.

Contractors:

The following contractors play critical roles in ensuring the SIM project is coordinated across many areas and supplement the work of SIM staff. A brief description of the contractors and their roles and responsibilities follow below:

Contractor	Awardee	Roles/Responsibilities
Management/ Implementation Contractor	McKinsey and Company, Inc.	The Management Consultant subcontractor will work with the Innovation Center Director and Executive agency staff to facilitate APC implementation.
Evaluation Contractor	TBD	The Evaluation subcontractor will work with the Innovation Center to define a robust evaluation methodology to measure process and outcomes during the four year grant cycle. The methodology will include the collection and analysis of data from the regional programs as well as survey data from program participants. The contractor selected will also be available to work with CMMS-designated evaluators to ensure data and other needs are met.
Communications Contractor	Rueckert Advertising & Public Relations	The Communications Consultant will support the State Innovations Model (SIM) initiative through development and implementation of a communications strategy intended to educate and inform health care providers, payers and

		consumers of the benefits of this new care delivery model and of how this new care delivery model aligns with and supports numerous emerging health policies, programs and initiatives.
Independent Third Party Practice Assessor	TBD	The Third Party Practice Assessor will evaluate and report physician practice progress towards established goals and assess the quality of the technical assistance provided by the Practice Transformation Vendors.
Practice Transformation Consultant/ Advisor	Lake Fleet, LLC	The contractor will provide consultation services to assisting the drafting and coordination with the upcoming \$22.5 million dollar RFA for practice transformation in Year 2.
Interim APD Data Aggregator	TBD	The contractor will collect billing, clinical and quality data about practices from various sources in order to assess progress prior to commercial data being available in the APD.
SHIN-NY Consultant	Kuvop, LLC	The contractor will support the Innovation Center by providing advice on how best to structure health information exchange activities in New York State in order to support goals of integrated care delivery and the health information exchange.
Health Economist	TBD	The contractor support the Innovation center by providing advice on how best to structure health information exchange activities in New York State to support goals of integrated care delivery, health information exchange and health information transparency efforts.
Measure Standardization Contractor	United Hospital Fund - Quality Institute	The contractor will work closely with Innovation Center to develop standardized measures and ways for practices to collect data.
Physician Retention	TBD	The contractor will work with the Department of Health and the Workforce workgroup to develop physician retention strategies for underserved areas.
Rural Residency	TBD	The contractor will work with the Department of Health and the Workforce workgroup to develop and begin a residency program targeted to rural areas.
Workforce strategy advisor	SUNY Center for Health Workforce Studies	The contractor will work closely with Innovation Center to support the development workforce strategies.
Value-Based Insurance Design Contractor	The Value-Based Insurance Design Center/University of Michigan	The contractor will have an advisement role with the Department of Health and the Department of Civil Service as it develops a value based insurance design benefit for state employees.

Employer and Self-Insured Engagement Contractor	The Northeast Business Group on Health	Work with Innovation Center, Department of Financial Services, and workgroups to create a common agenda and plan of action to improve care, reform payment, and align measures and benchmarks with employers and payers statewide.
Practice Transformation Technical Assistance Consultant Contracts	TBD	The Practice Transformation Consultants will be aligned with health system regions across the state. The amount awarded to each region will vary based upon size, number of practices, previous resources committed to the region and other factors determined by the Integrated Care Workgroup. The PCTCs will work closely with practices that have been approved through a needs assessment process and will devote up to two years working with these practices. Included in the practice transformation activities by the PTCT are on-site coaching, webinars, learning collaboratives and other services. Total system investments in APC practice transformation are estimated at \$210-220 million over the course of the 5-year SHIP implementation (based on grants benchmarked at \$18,000-\$24,000 per practice per year for an average 1.5 years, for an estimated 75% of all practices who will meet criteria to receive these funds). The State anticipates a co-funded approach with payers and providers, wherein the State will invest \$61.5 million in SIM funds over the first 3 years, and payers and providers invest in the remainder at an approximate 75/25 share, respectively (see project narrative/financial analysis).
Public Health Consultant contracts	TBD	The Public Health Consultant contractors (PHCs) will be aligned with the designated PHIP in 11 regions across the state. The PHCs will be procured separate from the PHIPs but housed in these agencies and provide support for the Practice Transformation Teams. The PHCs will work closely with practices that have been approved through a needs assessment process and will devote up to two years working with these practices.

b) Governance: 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Govern and manage Innovation Center staff	Identify initiative needs and hire staff accordingly	SIM Staff	\$1,881,290	Efficient and effective achievement of stated goals and objectives	Staff hired and work is progressing as scheduled

Create office strategic mission and vision		N/A	N/A	“	Clarity of roles and responsibilities
Establish regular and ongoing communications – internal and external	Internal communications through emails and meetings; external communications through newsletter; sharing of resource and posting materials on the Department website	N/A	N/A	“	Clarity of respective roles; intersection and coordination between initiatives and anticipated goals and outcomes

c) Risk Assessment: Governance and management structure

Risk Identification	Risk Probability	Impact	Overall Priority
Lack of clarity on roles, responsibilities and lines of communication and decision making authority across SIM areas	L	M	M
Staff resources inadequate to achieve milestones or deliverables on time	M	H	H
Changes in federal rules or guidance that conflict with planned activities	M	H	H
Critical needs identified that are outside of project scope	M	H	H

Mitigation Strategies:

- Scale projects to staffing available
- Seek additional funding or leverage existing resources to meet goals on time and budget
- Coordinate with other CMS, HHS, and federal or local initiatives
- Negotiate with other states as well as federal agencies to achieve agreement on actions necessary at all levels to implement health care reform within the scope and scale of New York's approved model test
- Monitor activities of federal agencies developing rules and participate in/comment on proposed rules that impact efforts
- Develop or revise project plans to adapt to federal or state regulatory requirements
- Track issues and identify potential resources for future projects, seek additional resources or reallocate existing resources if necessary
- Develop a SIM Operational Team charter that delineates roles, responsibilities and lines of communication and process to escalate issues for resolution if necessary
- Bring issues requiring resource allocation or with policy implications to the SIM Steering Committee for resolution
- Use the SIM Operational Team as a platform to coordinate activities and communicate about success and issues as they arise
- Use team building processes and activities to build shared understanding of project goals and outcomes
- Use performance reviews to assure continued high performance
- Establish and communicate strategic priorities
- Coordinate timely and effective communications
- Operate a robust learning management system.

6. PRACTICE TRANSFORMATION TO ACHIEVE ADVANCED PRIMARY CARE

a) Narrative Summary

New York's SIM initiative will invest significant federal resources to assist primary care practices in transforming to a highly integrated, team-based care model that is inclusive of

targeted care management, as well as some level of shared risk reimbursement. Over the coming year, New York will, with expert external stakeholder collaboration, operationalize the APC model.

New York will begin to draw on approximately \$12 million dollars of the SIM grant award to support practice transformation in order to achieve an ideal blend of consistency, flexibility, goal-setting, leadership, practice facilitation, workflow changes, outcome measurements, and adapting organizational tools and processes to support a team-based model of care delivery. Practice transformation support will be predicated on an initial evaluation of practice readiness. This funding would complement TCPI and DSRIP funding (targeted to safety-net practices) in order to assure alignment and consistent messaging across multiple payers and providers.

Programmatically, the APC model is defined as a set of capabilities that describe the practice in terms of the following:

- Provision of patient-centered care;
- Support and promotion of population health;
- Care management and coordination capabilities;
- Competencies and practices to promote access to care;
- Use of HIT;
- Readiness for alternative payment model(s); and
- Quality measurement and improvement activities.

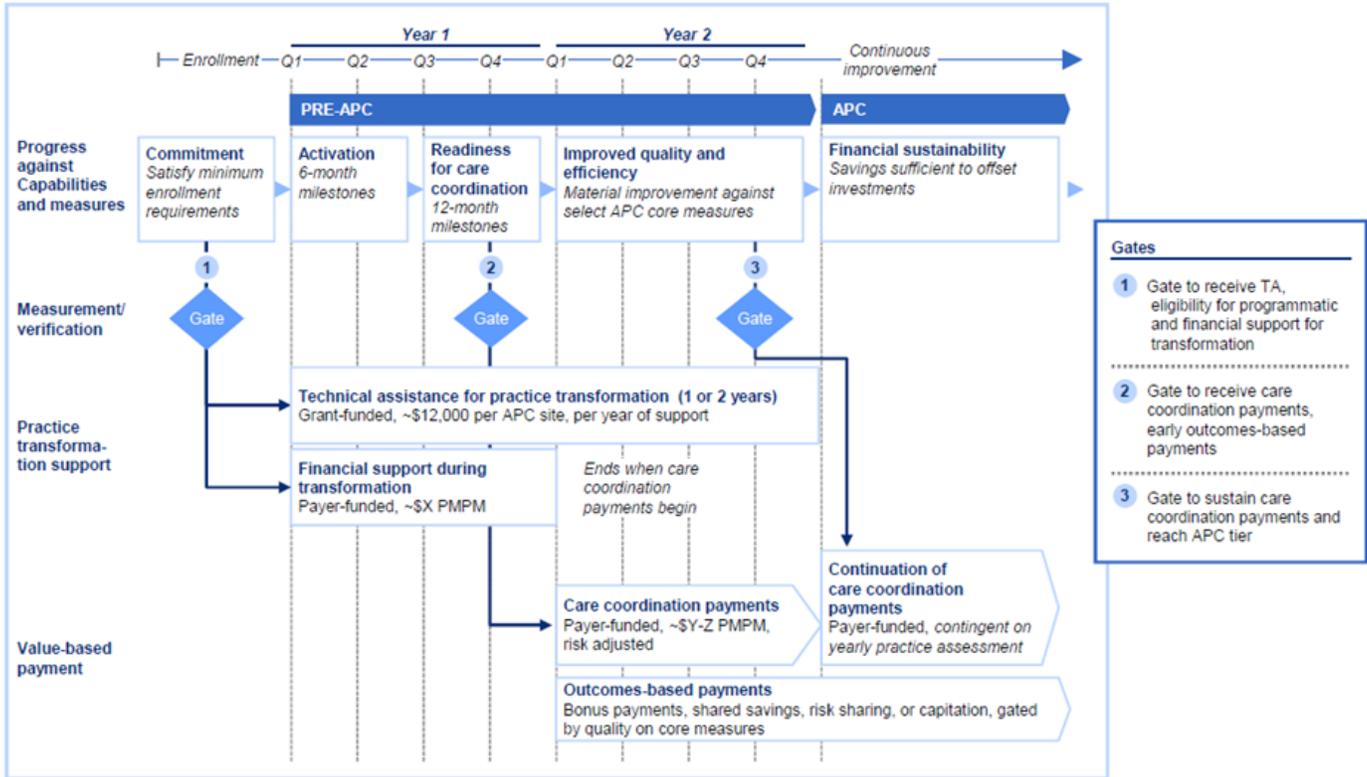
To gauge a practices' readiness for alternative payment arrangements, APC employs a set of standards and milestones. Practices will be provided support to achieve a core set of

capabilities and will be evaluated, by both the transformation vendors as well by an independent third party, in terms of their passing “Gates” which are linked with payment incentives. These Gates are described below:

1. Gate 1 represents initial practice commitment and initiation of SIM and payer-provided support (technical assistance through SIM-funded transformation agents and financial assistance from payer through lump sum, PMPM or other model (still in discussion)). This represents an initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff, or re-training existing staff.
2. Gate 2 indicates a readiness for practices to provide and be reimbursed for care coordination. Support at this Gate would be for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support ‘shared savings’ payment. In the early years of the APC’s operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not likely (yet) generating cost savings.
3. Gate 3 is achieved through material improvement in select APC measures and suggests a readiness for outcome-based payment (specific models in discussion). At this point, the practice is likely to be ready for ongoing support. It is envisioned that once the APC model has begun to have a measurable impact on total cost of care and generate measurable savings, the practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

FIGURE 6: PATH TO APC

Review: Path to APC over time for practices starting out



b) Practice Transformation 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Convene statewide stakeholder group - providers, payers and consumers	Identify, engage and regularly convene representative stakeholders	SIM Staff	\$104,184	Consensus development of care delivery and payment model and core metrics	Workgroup established and monthly meetings convened
Release practice transformation RFP and contract with regional TA entities	Secure contracted entities to conduct practice transformation	SIM Staff	\$12,000,000	Ensure 80% of practices evolve to achieve APC status	Contracts in place by Q2 2016; Beginning of delivering TA (Q4) to practices who are early adopters and have 60% payer critical mass

Release practice self-assessment tool	Common tool for provider self-assessment to inform future TA need(s)	SIM Staff/DOH/Lake Fleet, LLC	\$50,000	Ensure 80% of practices evolve to achieve APC status	Distributed to practices by Q2 2016
Release of practice transformation auditor RFP	Contract with TA providers to assist providers with achieving APC milestones	SIM Staff	\$500,000	Ensure 80% of practices evolve to achieve APC status	Contract (s) in place Q2 2016
Development/release of Gating tool	Practice transformation entities evaluate practices to determine level of sophistication and TA need(s)	PT Vendors	Included in above RFP funding	Ensure 80% of practices evolve to achieve APC status	Beginning of Gating (Q3 or Q4)
Development/launch of APC provider portal (for vendors and practices to use to enter information, enrollment, gating status, etc..... and which may be one and the same with, or at least interoperable with, the TCPI platform)	Assure maximal efficiencies in dedication of resources across practices and between funding sources	Interim data solution entity	Including in data collection funding		Q3 2016

c) Risk Assessment and Mitigation

Lack of voluntary compliance with test model

Risk Identification	Risk Probability	Impact	Overall Priority
Provider reluctance to participate; confusion with multiple entities and or other changes such as participation in ACO	M	H	H
Applicants to be TA entities not qualified, either statewide, or in certain regions	M	M	M
Confusion between DSRIP, TCPI, and SIM PT funding	H	M	M

Mitigation Strategies:

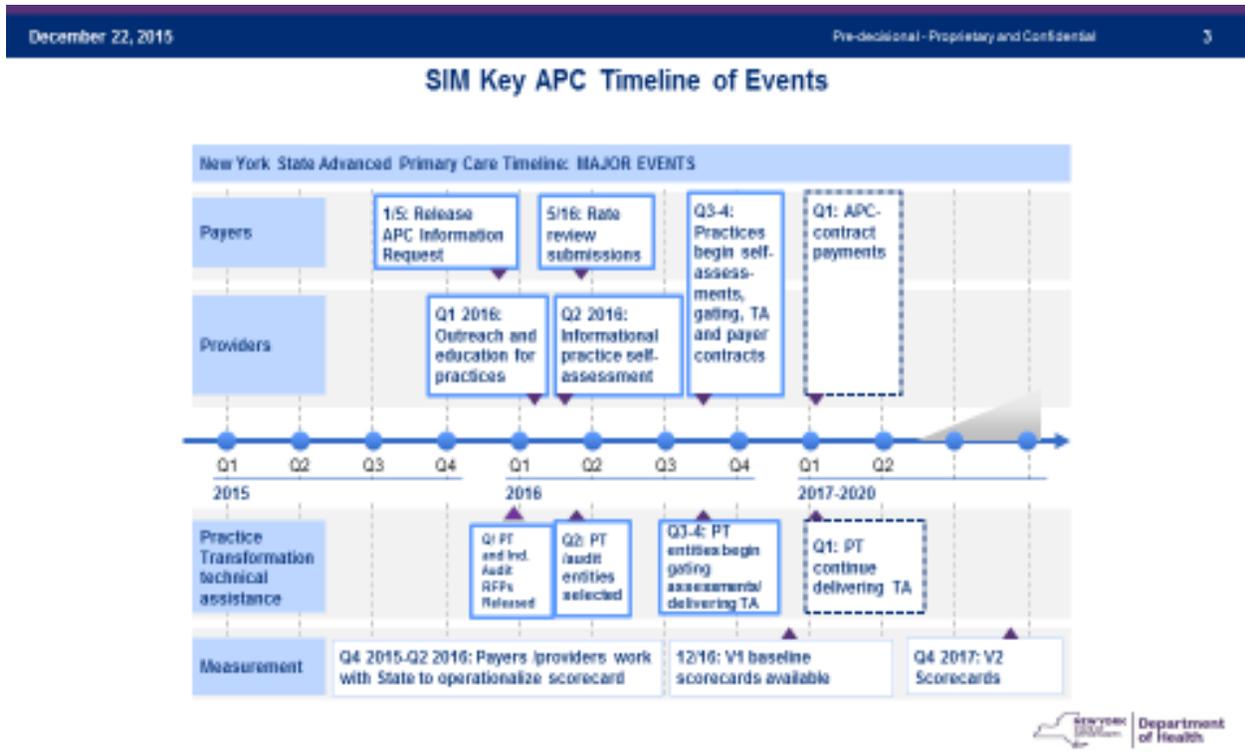
- Engage state leadership for identifying potential shared solutions.
- Develop recommendations for policy changes necessary to implement required compliance for appropriate legislative or administrative action.
- Continue one on one conversations
- Evolve model and discussions to reflect evolving care delivery models such as ACOs
- Re-procure for uncovered areas or negotiate with existing contractors for additional coverage
- Maintain consistent communications at state, federal, and local level to ensure clarity of resources, message, and consistency of desired outcomes.

7. PAYER ENGAGEMENT

a) Narrative Summary

Discussions are currently underway with payers on their plans for adoption of APC. NYSDFS will release an information request to payers to better understand how they would implement APC based on a proposal of detailed business requirements for plans to be considered as participants in APC. It is anticipated that the information request will be released in January 2016 after additional opportunities for refinement, based on feedback from the plans to ensure the questions and supporting documents, are clear and provide enough information for detailed responses. Responses are anticipated to be delivered back to the state in early February, and will serve as a basis for securing payer commitment to APC and final model refinements as necessary. A timeline follows below.

FIGURE 7: APC TIMELINE



The SIM goal is for all payers participating in APC to offer contracts compatible with APC guidelines to providers meeting APC milestones. An independent third-party will be funded by the State (SIM) to evaluate practices with respect to attainment of milestones that trigger payment and report this information to payers. Payer financial support will vary according to demonstrated practice capabilities as measured by the three Gates in APC.

Multi-Payer Alignment – APC Current Assumptions: Current planning for APC roll out includes the following potential process and necessary commitments from payers to be considered APC and thus participant in this multi-payer initiative. Payer discussions are currently in process including individual one-on-one meetings as well as multi-payer group meetings. As of December 2015, below is the current strategy. The APC program will be rolled out on both a regional basis and a practice-specific basis according to the following:

1. Regions will be defined as the 11 Population Health Improvement (PHIP) regions.⁴
2. The roll-out process will “activate” practices and regions as they meet specific payer and practice participation thresholds (detailed below). When a practice is activated:
 - a. SIM funding for practice transformation support by a TA entity can be disbursed from the State to the TA entity.
 - b. Practice transformation, care coordination, and outcome-based payments specified in the practice’s contracts with payers, and as appropriate given the practice’s current Gate, must be disbursed from payers to the practice. Payers are

⁴ https://www.health.ny.gov/community/programs/population_health_improvement/docs/contact_sheet.pdf

welcome to make these payments earlier, but must at least make the appropriate payments based on practice Gate. Payers without APC-qualified or otherwise Gate-dependent contracts with the practice would not be obligated to disburse these payments after practice activation.

3. Regions will be activated once 60 percent of the patients in that region are attributable to payers that have agreed to participate in the APC model.
4. Practices will be eligible for practice transformation technical assistance if the practice is within an activated region and 60 percent of its patient panel is attributable to either:
 - a. APC-qualified contracts of APC-participating payers, or
 - b. Other qualified outcome-based payment contracts of APC-participating payers.

These contracts must meet the criteria described by CMS as Level 3 (“Alternative payment models built on fee-for-service architecture”) or Level 4 (“Population-based payment”) to be “grandfathered” in to the roll-out process in this way.

5. The State will create a master attribution system, taking into account attribution data and other input from payers and providers, that will serve as a single source of truth for the activation status of regions and practices.
6. Practices within a given region are permitted, but not required, to enter into APC-qualified contracts with payers before the practice is activated.

Commitments Necessary to be Considered a Payer that Supports APC:

Payers will play a critical role in the success of the APC program. Payers must make the following commitments in order to be considered an APC-participating payer:

1. APC-participating payers are expected to develop contracting arrangements that meet the minimum guidelines of APC. These APC-qualified contracts support the

- transition of practices to APC by offering investments in participating practices as they make cumulative structural and performance improvements.
2. APC-participating payers are expected to offer an option for practices to be contracted with APC-qualified contracts. This option could involve either amending the practice's current contract so that it satisfies the minimum guidelines, or contracting the practice into a new APC-qualified contract.
 3. APC-participating payers are expected to offer this option to all practices in their network in which at least 60 percent of the practice's patient panel will be attributed to a participating payer. This option must be offered in all lines of business.
 4. Payers will be expected to report to the State data from primary care practices in their network relevant to the APC Core Measures including data from all lines of business. This data will be used by the State to generate a provider scorecard that will track the performance of practices statewide. Payers are encouraged to be partners in the development, testing, and operational planning for this data reporting requirement.
 5. APC-participating payers are also encouraged to provide in-kind support to practices, to maximize the likelihood of practices' successful transition to an outcome-based payment and the APC care delivery model.

Payer Engagement: Common Measure Set and Scorecard:

In addition to financial support, payers participating in APC will be sharing claims and quality data with the State. Meetings will begin in January 2016 with a strategic group of payers to discuss scorecard operationalization (e.g., with technical/measures experts at priority payers to align on proposed technical specifications for scorecard) to inform the development of the

interim solution until the APD is available to allow for a smooth transition for payers and for the collection of this data.

b) Payer Engagement 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Convene regional and payer specific meetings	Engage commercial insurers to socialize APC payment model	NEBGH	\$251,395	Consensus development of care delivery and payment model and core metrics	Monthly meetings scheduled to continue throughout 2016
Convene employer groups including large self-insured	Engage employers to socialize APC model	NEBGH	\$151,395	Consensus development of care delivery and payment model and core metrics	Monthly meetings convened throughout 2016
Convene employee benefits managers stakeholder meeting	Engage employers to socialize APC model	NEBGH	\$151,395	Consensus development of care delivery and payment model and core metrics	Monthly meetings convened throughout 2016
Release request for information to payers	Secure initial information to guide rate submission guidance in support of APC	SIM Staff/ DFS	N/A	Ensure 80% of practices reimbursed using outcome based payment model that supports APC	Achieve a regional payer alignment of 60% by Q1 2017
Payer rate submission and State review to ensure consistency with/support of APC. This must include agreement to - Plans for funding Practice Transformation and Care Coordination - Plans for outcome-based payments, including VBP model type, % of shared savings (if applicable) - Measures that will be used to qualify for payment	Assure payer alignment	SIM Team/DFS	N/A	Ensure payer participation in APC	Rate review Q2-3 2016

Payers commit funds to practices to enable change.	Financial support for team-based care transition	SIM/ DFS	N/A	Ensure 80% of practices reimbursed using outcome based payment model that supports APC	Contracts with initial APC payment Q1 2017
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c) Risk Assessment and Mitigation

Risk Identification	Risk Probability	Impact	Overall Priority
Stakeholder reluctance to participate due to financial disincentives or conflict of interest	H	H	H
Lack of Payment reform progress Lack of progress in reforming payment in designated timeline	M	H	H
Overall model not financially sustainable - payers do not support either initial or ongoing investment in practice transformation or outcome-based payment models	M	H	H
Payers have VBP models but they are not aligned with APC	M	M	M
Free riders	M	M	M
Unable to reach 60% payer critical mass	M	H	H
Medicare does not participate	M	H	H

Mitigation Strategies:

- Examine aspects of the APC model that challenge sustainability and make appropriate adjustments.

- Rescale the model as necessary to sustain the greatest benefits and offset the most important detractors from sustainability.
- Continue strong, early, and sustained stakeholder engagement.
- Establish shared vision, goals, and actions.
- Provide strong, high level state leadership to support success.
- Utilize all necessary levers to ensure success.
- Engagement with CMMI for technical assistance as necessary.
- Conduct rigorous engagement activities to understand the payer environment.
- Conduct broad environmental scan to identify similar issues and solutions developed in other states.
- Identify areas of possible common interests and develop shared goals.
- Engage state leadership for identifying potential shared solutions to minimize financial disincentives.

8. APC COMMON SCORECARD

a) Narrative Summary

The common measure set was created in the context of the spread and scale of the advanced primary care model, as one of the three pillars of the APC – 1) competencies and milestones, 2) core measures and 3) payment and transformation support. The goal of the common measure set is to drive the triple aim. As the set was created, priority was given to ensuring fit to purpose and ensuring it would be meaningful to stakeholders – consumers, providers to guide their quality improvement strategies, and payers as basis of value-based payments.

There is a concerted effort nationwide to simplify and improve the impact of our healthcare measurement enterprise⁵⁶⁷⁸. The New York APC Common Measure Set aims to creatively address measurement burden and targets measures that matter. The goal is for the set to be used across payers, providers and regions of the state. A number of principles and selection criteria for the measures were adopted:

- a. National endorsement and standard specifications.
- b. Alignment and parsimony with major state and national reporting programs
- c. Relevance to broad-based population and care needs - prevention, acute illness and chronic conditions
- d. Variation is significant, gap in performance and New York health priorities

⁵ BPC Report April 2015 – Consolidation and Alignment of Quality Measures;

⁶ Shadac, May 2015 Aligning Quality Measures across payers;

⁷ IOM Vital Signs, HA blog;

⁸ Bazinsky and Bailit: The Significant Lack of Alignment Across States and Regional Health Measure Sets, September 2013

- e. Balance of structure, process, outcomes and utilization
- f. Ease of collection and reporting.
- g. Utility at multiple levels (person → provider → system → state)

Each measure in the set was vetted according to those principles. Additional feedback from stakeholders was obtained through monthly updates to the members of the SIM Integrated Care Workgroup from June – December 2015, through 8 regional meetings and webinars held with groups of providers and payers, through meetings with plans convened by the Northeast Business Group on Health, and through one on one meetings with select health plans.

The Common Measure set is shown below. It consists of 20 measures that are all NQF endorsed, are relevant to a broad population and care needs, and are feasible to collect.

FIGURE 8: APC COMMON MEASURE SET

Domains	NQF #	Measures
Prevention	34	Colorectal Cancer Screening
	33	Chlamydia Screening
	41	Influenza Immunization - all ages
	38	Childhood Immunization (status)
	2528	Fluoride Varnish Application
Chronic Disease	28	Tobacco Use Screening and Intervention
	18	Controlling High Blood Pressure
	59	Diabetes A1C Poor Control
	1799	Medication Management for People With Asthma
	24, 421	Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults
Behavioral Health/ Substance Use	418	Screening for Clinical Depression and Follow-Up Plan
	4	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Patient-Reported	326	Advance Care Plan

	5	CAHPS Access to Care, Getting Care Quickly
Appropriate Use	52	Use of Imaging Studies for Low Back Pain
	58	Avoidance of Antibiotic Treatment in adults with acute bronchitis
	--	Inpatient Hospital Utilization (HEDIS)
	1768	Plan All-Cause Readmissions
	--	Emergency Department Utilization (HEDIS)
Cost	--	Total Cost Per Member Per Month

The common measure set aligns with the APC competencies – for example, if a practice has in place all the processes to guarantee access to care to its patients, this competency would be reflected in a measure of quality – in this case, patient reported getting care in a timely fashion.

The common measures were mapped to the APC core competencies and the relationship between the two is shown below.

FIGURE 9: APC COMMON MEASURE SET AND APC CORE COMPETENCIES

Mapping APC Standards (core competencies) to APC Core Measure Set

APC Standard	Competencies Linked to Measure Set	Core Measure Set
Patient Centered Care: 2 Major Competencies	i. Access to care in a timely way	14. CG-CAHPS – Getting Care Quickly
	ii. Advanced directives	13. Record Advanced Directives
Population Health: 5 Major Competencies	i. Proactive management of panel of patients who need preventive care	1. Colorectal Screening 2. Chlamydia Screening 3. Influenza Immunization 4. Childhood Immunization 5. Fluoride Varnish
	ii. Proactive management of panel of patients who need chronic care management	6. Tobacco Use Screening and Intervention 7. Controlling High Blood Pressure 8. Diabetes A1C Poor Control 9. Appropriate Medication Mngt for People with Asthma 10. Weight Assessment and Counseling for Nutrition and Physical Activity for Child, Adolescent and Adult
	iii. Providing patients with self-management resources (in-house, community)	No direct measures, these competencies are part of management of patients with chronic conditions and others as appropriate.
	iv. Providing patients with appropriate community-based services	
	v. Reducing disparities	
Care Management: 2 Major Competencies	i. Proactive management of high risk patients (5% who consume 50% of services)	17. Avoidable Hospitalizations 18. Avoidable Readmissions 19. Emergency Dept. Utilization 20. TCOC
	ii. Management of patients with BH and substance abuse	11. Depression Screening and Management 12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Care Coordination: 2 Major Competencies	i. Proactive management of patients during care transitions	18. Avoidable Readmissions 19. Emergency Dept. Utilization
	ii. Proactive management of specialty referrals	No direct measures of quality; this competency will be reflected in outcomes of care, in TCOC, and could be tracked with CG-CAHPS: getting referral care quickly
Access to Care	i. 24/7 access to provider – in-person, phone, tele-video, asynchronous	14. CG-CAHPS

2016 APC Common Measure Set Work Plan

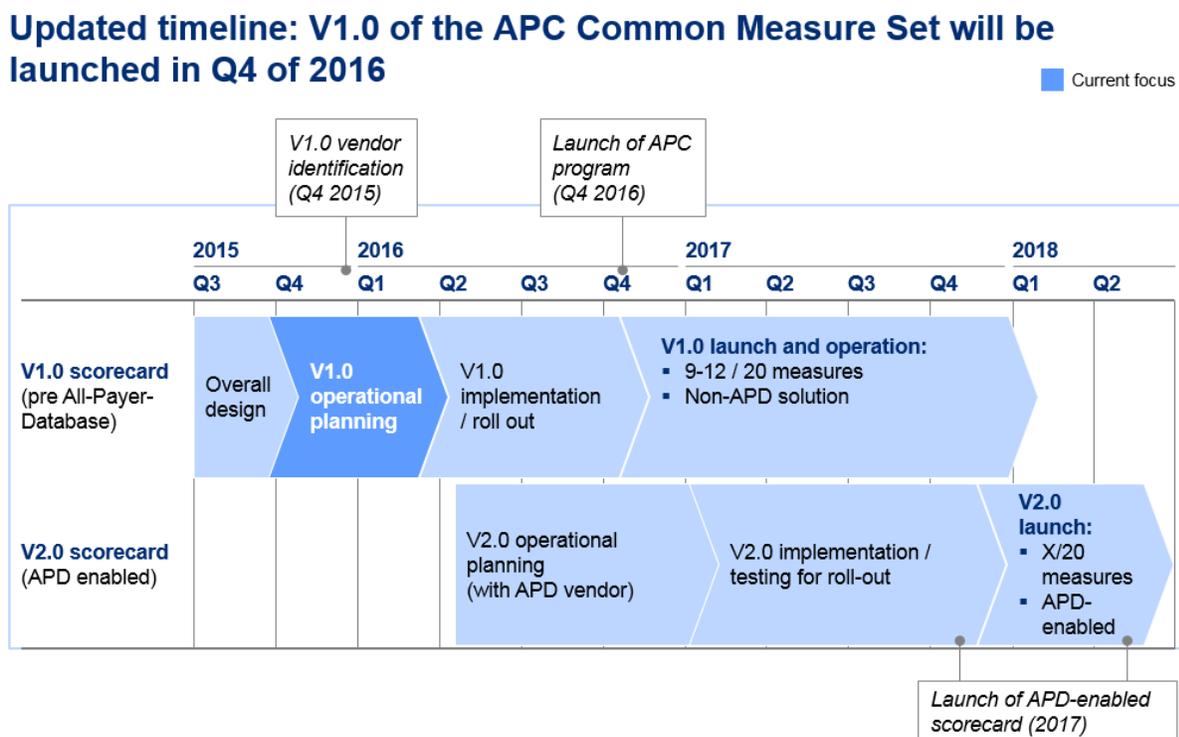
To promote implementation and use of the common scorecard for quality improvement, the State has requested continued funding from SIM to support the Quality Institute, a public-private partnership created under the auspices of the United Hospital Fund as a neutral, trusted convener with the capacity to bring Quality Improvement experts and stakeholders from across the continuum of care together to generate ideas, initiatives, and consensus. The Quality Institute will support and promote collaboration and organizational change necessary for alignment and adoption of quality metrics.

With an agreed upon set of common metrics, the next task targets implementation – 1)

data collection, analytics and production of APC Common Measure Reports and 2) use of the reports to guide quality improvement and value-based payment.

Given that there are three sources of measures, those that can be collected via claims only, those that require clinical data obtained from medical records, and patient reported data, strategies and tactics to collect data will need to be clearly defined depending on the source of the data. Below is the working timeline for producing APC reports.

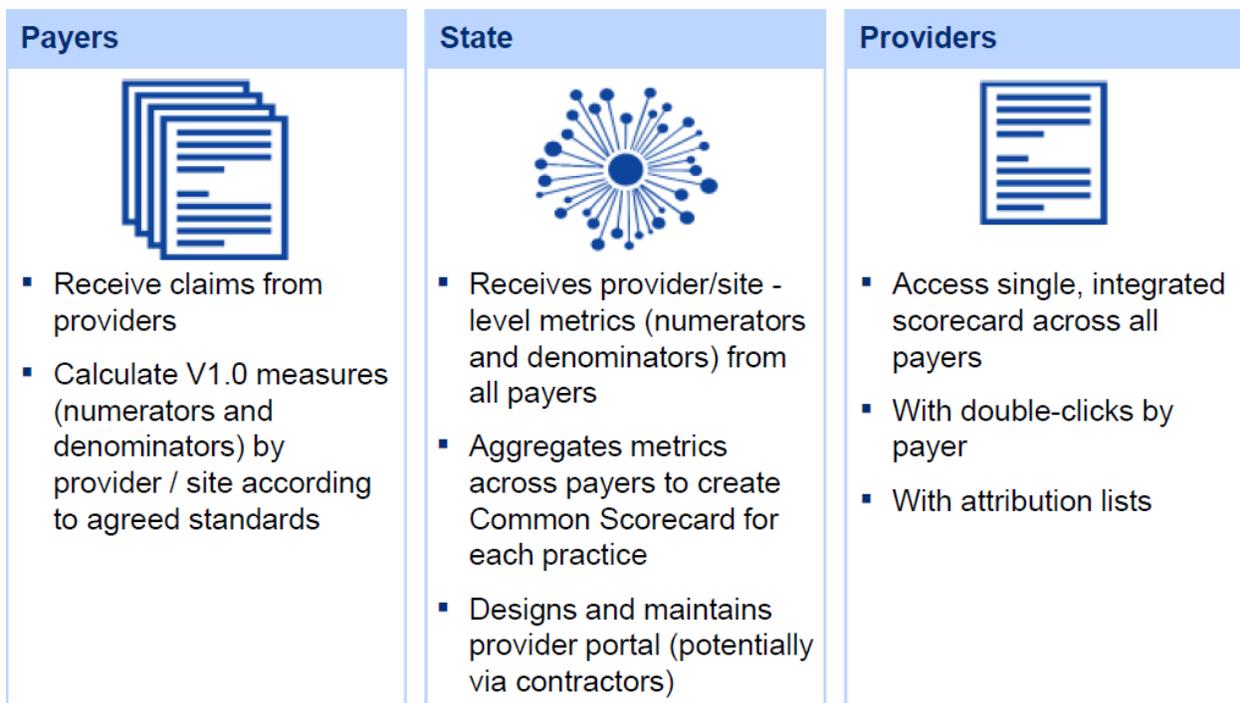
FIGURE 10: WORKING COMMON MEASURE SET TIMELINE



- 1. Claims-based measures** - In terms of feasibility, a first version of the Common Measure set V1.0 will be developed using claims data only (12 measures). This first version is required to assure implementation of APC by Q4 2016, for gating and payer performance assessment. Since this key information is needed in advance of a fully functional APD, which is not

anticipated to be complete until late 2017, the State is now engaged in developing a work plan for an interim solution to secure data collection and analytics that will fit the APC roll-out timeline. The graphic below portrays initial thinking for the interim scorecard. The goal is to produce a baseline report profiling APC practices on the 12 claims-based measures 6 months after the APC contracts are signed. This will require working with payers to resolve pending alignment and other technical and methodological issues including, for example, unit of reporting: how to identify a practice/site and attribution: how to attribute members to practice/site.

FIGURE 11: INTERIM SCORECARD OPERATIONS



2. Non-claims based measures - clinical, patient reported. The Common Measure Set includes six measures that require clinical information from provider medical records and two measures that are reported by patients. In addition, providers need to reduce disparities, which will require that they collect socio-demographic information to profile various

population groups on the Common Measure Set. The goal is for providers to collect and report on those measures by Q1 2017. The State will be developing strategies to support and guide providers in effective approaches to collect and report this information. In comparison to claims-based measures, the collection and reporting (e.g., clinical, survey, socio-demographic) is more complex and requires special attention to practice workflow, facility with clinical data/medical records/registries, and staff and financial resources. Some of the measures in the Common Measure Set present additional and specific complexity for providers who will need guidance as to best practices,

3. Patient-reported outcome measures - (e.g., patient reports based on items in the CAHPS survey, obtaining Advance Directives)

In addition to the above, disparities/population health data, will be essential to stratify measures by patient characteristics such as race/ethnicity, language, age/gender, and health status, a prerequisite to achieve the APC milestone of reducing disparities. Targeting groups of patients to special programs or interventions by clinical and/or social complexity will require that practices to have a strategy to identify high risk patients.

The measures in the Common Measure were selected if e-specifications exist. Over time, in addition to the APD, providers would be expected to report clinical measures electronically through the SHI-NY. The State will conduct work to set the stage and infrastructure for APC practices to eventually have the capacity to report e-measures via the state health information exchange.

4. Use of the APC Common Measure Set to Drive Quality - the Common measure set will be central to:

- Practice transformation initiatives – at launch of APC

- Ongoing performance improvement – at launch and ongoing
- Value-based payment – at launch and ongoing

The goal of the Common Measure set is to drive quality, so that beyond collection and reporting, practices will have to create mechanisms to review the data and use it for care management or quality improvement. Once reports are available, the process by which they are “socialized” will be important. How the information is shared with practices, how often, and what the reports then set into motion in terms of improvement activities within the practice teams – all are critically relevant to the success of the APC model.

New York will focus on strategies and best practices to ensure effective adoption of the Common Measure Set by providers by describing: i) current capacity of New York providers to collect, report, and use information that will be provided in the APC Common Measure Set report, ii) best practices for quality improvement infrastructure to move from quality measure data to action in New York.

Rapid cycle improvement work with the practices will be facilitated through the DOH’s contract with the UHF Quality Institute. Measurement information from practices will be shared with UHF and targeted interventions will be piloted among practices that cannot attain statewide and or regional benchmarks. The UHF will routinely review relevant literature, partner with experts in the field and transformation entities to address improvement needs of the practices.

Keeping the APC Common Measure Set Up-to-Date

As the Common Measure Set is implemented, a number of issues with the measures themselves will inevitably arise. Some will be technical (quality, accuracy) or methodological (risk adjustment, attribution methods), and others will relate to the broader context of how one

measures quality of an advanced primary care practice, and how quality gets rewarded. Over time, some measures with national endorsement may lose endorsement, get retired, or updated. There may be measures that “top-off” as to performance, problems may arise around a specific clinical problem, calling for a reassessment and selection of measures that are more timely and relevant. Evidence-based guidelines may lead to new recommendations as to best practices, and these would impact measures. For example, CMS is developing a measure of readmission that would assess the intensity of a patient’s interaction with institutional care after discharge – in terms of time spent in an ED, a SNF, a hospital as an index of inappropriate care transition planning and execution. The Common Measure Set will need to reflect those changes when they occur.

Identifying APC Benchmarks

The State is considering several options to establish benchmarks for performance on the APC Common Measure Set: APC practices could be compared to their own historical trends; or a payer-based benchmark. Most commercial payers use these two types of benchmarks. Ten measures in the Common Set are aligned with the New York State Prevention Agenda. For these, the State will be exploring using the specified targets as noted (see below).

The New York State DRSIP program has also specified targets that will be reviewed for potential application and alignment for APC benchmarks. The New York State QARR (Quality Assurance Reporting Requirements), which is the New York State Department of Health's version of the national Health Plan Employer Data and Information Set (HEDIS), has been collecting and reporting on many of the measures selected in the Common Measure Set. Performance is reported at plan level for commercial HMO, commercial PPO, and Medicaid.

These could also serve as benchmarks for APC performance. In addition, HEDIS also publishes similar performance at the national level, which could guide decisions about New York State APC benchmarks.

APC Common Measure Set Aligned with Prevention Agenda (and Prevention Agenda targets)

Colorectal Cancer Screening

- Increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines to at least 71.4 percent by 2017.

Chlamydia Screening

- Reduce chlamydia case rate among females aged 15-44 years of age to no more than 1,458 cases per 100,000 by 2017.

Influenza Immunization - all ages

- Increase flu immunization rates of adults aged 65 years and older to at least 66.2 percent by 2017.

Childhood Immunization (status)

- Increase the rates of 19-35 month olds with the 4:3:1:3:3:1:4 series (4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13) to 80 percent or higher by 2017.

Controlling High Blood Pressure

- Percentage of health plan members (commercial managed care) with hypertension, who have controlled their blood pressure should increase to 69.3 percent by 2017.
- Percentage of health plan members (Medicaid managed care) with hypertension who have controlled their blood pressure should increase to 72 percent by 2017.

Diabetes A1C Poor Control

- Percentage of adult health plan members (commercial managed care) with diabetes, who have blood glucose in good control should increase to 60.5 percent by 2017.
- Percentage of adult health plan members (Medicaid managed care) with diabetes, who have blood glucose in good control should increase to 62 percent by 2017.

Screening of Clinical Depression and Follow-up Plan

- Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month should be 10.1 percent by 2017.
- Percentage of adolescents (youth grades 9-12) who felt sad or hopeless should be 22.4 percent by 2017.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- Percentage of adolescents (youth in grades 9-12) reporting use of alcohol on at least one day for the past 30 days should be 34.6 percent by 2017.
- Percentage of adolescents (youth aged 12-17 years) reporting non-medical use of painkillers in the past year should 4.36 percent by 2017.
- Age-adjusted percentage of adult binge drinking during the past month should be 18.4 percent by 2017.

Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults

- Percentage of children and adolescents (NYC) who are obese should decrease to 19.7 percent by 2017.
- Percentage of children and adolescents (NY state, excluding NYC) who are obese should decrease to 16.7 percent by 2017.

- Percentage of adults who are obese should decrease to 23.2 percent by 2017.

Tobacco Use Screening and Intervention

- Decrease the prevalence of cigarette smoking among adults to 15.0 percent by 2017.

b) Common Scorecard 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Create and implement core measure set	Socialize, development and secure consensus on core set of quality and utilization measures	United Hospital Fund -Quality Institute	\$232,953	Ensure 80% of New Yorkers receive care through an integrated care delivery model	Reports profiling APC practices on claims-based measures available for practices and payers by Q1 2017
Interim Solution: Identify entity to collect, store and share key data elements in advance of full APD implementation	An interim approach to data collection, sharing and aggregation is needed to ensure timely implementation of APC in advance of APD implementation	TBD	\$300,000	Ensure 100% of designated APC providers report 8-10 common metrics	Ten percent of practices/providers participating in APC in 2016 provide data for the common scorecard
Ensure successful collection and reporting of clinical and survey (non-claims-based) measures in the APC Common Measure Set	Secure expert guidance on the APC common measure set and on a second broader set of core measures that address care issues across the health care continuum	SIM Team/United Hospital Fund	\$207,953	Assure access to valid clinical and patient data to profile quality based on APC Core Measure Set	60% of providers are reporting on non-claims based, clinical APC Common Measures by Q2 2017
Secure input on population health measures	Explore mechanisms for the collection of non-clinical health data to inform population health to better integrate health and “non-health” data (i.e., housing status, outreach efforts)	SIM/United Hospital Fund	\$357,953	Assure population health measures collected for informing practices, the State and CMMI	Proposed set of measures begin to be collected Q3 2016

Keeping the Common Measure Set Up-to-Date and Relevant	Develop mechanisms to ensure that APC Common Measure Set is up-to-date, relevant and used by payers and providers to drive the Triple Aim	SIM/United Hospital Fund			Common Measure set is current and used effectively by payers and providers; platform to resolve issues and prioritize quality is in place
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c) Risk Assessment and Mitigation

Risk Identification	Risk Probability	Impact	Overall Priority
Barriers to acquiring Medicare data to align with our data in our APC database to ensure we are seeing across the entire landscape as the model is implemented	M	H	H
Core measure set incomplete due to inability to collect data as envisioned	M	M	M

Mitigation Strategies:

- Conduct strong advocacy and partnership with CMMI to assist with timely Medicare data acquisition.
- Assure monthly review of data submission; follow-up with data aggregator and with providers to identify and address barriers to data submission.

9. HEALTH INFORMATION TECHNOLOGY (HIT)

a) Narrative Summary

New York State has a substantial Health IT Infrastructure that includes the Statewide Health Information Network of New York (SHIN-NY), a developing All Payer Database, as well as existing resources, such as SPARCS, the hospital discharge database. Further information about each of these systems can be found on the New York State Department of Health's public website (<http://www.health.ny.gov/>). These information systems provide benefits to many audiences and are integral to success of the APC model, including the ability to calculate total costs of care across the practice, to be able to best manage patient care through tools such as hospitalization alerts, and to better track referrals and follow-up.

New York has made sizeable investments in statewide HIT initiatives and will continue to support initiatives such as the SHIN-NY (\$55 million in Year 2) and All Payer Database (\$15 million in Year 2) over the life of the SIM grant and beyond.

The NYSDOH Office of Quality and Patient Safety oversees the two largest HIT initiatives funded by the state – the SHIN-NY and the APD. Both the SHIN-NY and the APD have formal venues for stakeholder input and active policy committees, comprised of internal and external partners, where policy questions are vetted and recommendations made. Regulations governing both the SHIN-NY and APD are fully vetted with formal public comment periods prior to enactment.

The SHIN-NY is a network of eight regional health information organizations (RHIOs), a hub for statewide services and a governance and policy process that outlines how clinical data is shared among healthcare providers. Each RHIO provides a minimum set of services such as query-based exchange through a web-based portal and, through integration with electronic health records, subscriptions to allow provider notifications for patient events such as accessing the

emergency department. Additionally, some RHIOs provide other services above and beyond the minimum set of services, such as analytics, development of population health registries and calculation of quality measures for providers. 86 percent of hospitals and approximately 20 percent of all provider practices currently participate in their RHIO. It is estimated that 60 percent of providers receiving Medicaid meaningful use incentive payment are currently participating in their RHIO.

The infrastructure for the SHIN-NY was first developed using HEALNY funding to support building health IT infrastructure across the state. The SHIN-NY infrastructure was further built out using HIE funding from the HITECH act. The SHIN-NY forms the basis for clinical interoperability for the SIM, DSRIP, and other coordinated care activities across New York State. For example, providers using certified electronic health record technology in PPS must connect to the SHIN-NY as a DSRIP requirement. This will allow patients' data to follow them as they move among providers and between PPSs. Similarly, APC providers would need to connect to improve clinical quality measures such as the measure on readmission. One of the minimum set of core services is the ability to provide notifications to providers when their patients access care elsewhere. This has been shown to be very valuable to providers when patients are admitted to hospitals.

NYSDOH will rely on electronic health records and the infrastructure of the RHIOs to gather, calculate and report clinical quality measures in a standards-based format. Multiple RHIOs have the ability to calculate electronic clinical quality measures (eCQM) and report them in QRDA1 or III format. With full provider participation, the RHIO infrastructure can be used to calculate information to populate the APC scorecard. NYSDOH will continue to work with the eCQM affinity group to identify lessons learned from other states in implementing eCQM

reporting. During SIM Year 2, NYSDOH will identify how it will support the reporting of clinical quality measures for the APC scorecard on a long-term basis.

Two RHIOs are taking slightly different approaches to population's level data analysis. One RHIO, HIXNY, is developing a series of population health disease registries through funding from the CDC to identify patients in different stages of hypertension and creating a single registry which will ultimately be used to notify providers of changes in patient hypertension status. Another RHIO, HealthIX, is in the process of implementing Query Health to populate a database using continuity of care document form the RHIO to be able to calculate population health measures. HealthIX is now focused on the quality of CCDs that are being used to populate the database. New York State will continue to identify ways to leverage these activities to support the SIM.

The goal of the APD is to provide policymakers, researchers, and consumers with the most comprehensive health data base in New York State, encompassing claims data from commercial, Medicaid, and Medicare insured New Yorkers. These data will be used for quality measurement, population health monitoring, value-based purchasing, and consumer information.

The APD will allow the State to support population health improvements through various analyses that would not be possible without health insurance claims data across all payers. These analyses will provide many opportunities for improvement, such as enabling targeted public health initiatives and interventions based on strategic assessment of health care disparities, identifying high-performing communities that provide cost-effective care and leverage that success to promote similar activities, and evaluating reform efforts to identify and duplicate successful initiatives, and identify opportunities for reform.

Some specific ways APD data can aid in improving population health include:

- Creating a tool for evaluation of population health metrics at the regional level.
- Providing a snapshot of a community's health needs by assessing the prevalence of various chronic conditions.
- Augmenting traditional public health data systems with detailed information on episodes of care. For example, the Cancer Registry collects limited information on chemotherapy and radiology. The APD will augment the Cancer Registry with data on chemotherapy treatments, pharmacy interventions, and radiology.
- Enabling case finding for Public Health reporting (e.g. HIV, other reportable diseases).
- Evaluating disparities across different providers and regions. APD design, development, implementation, and operations will be funded through a combination of state and federal sources that are cost allocated based on estimated covered lives in the database, and that have CMS approval via an IAPD through FFY 2018. Specific funding sources and allocation percentages include:
 - Medicaid (State/Fed) – 70 percent
 - Child Health Plus (State/Fed) – 6.36 percent
 - New York State of Health (Health Exchange) (State/Fed)– 7.27 percent
 - Off –Exchange Large Commercial (State) – 16.37 percent

FIGURE 12: APD TIME LINE



APD Data Intake (DDI) activities began in 2013 and began partial production in 2015. Incorporation of Commercial plan data in 2016 will complete the major components of data intake, and will be followed by continued focus on data submission compliance and validation of data beyond that. Full data validation across all payers is expected to be complete by 2018.

Data warehousing is currently being addressed by an interim plan utilizing the existing DOH OHIP DataMart for storage. A vendor will develop a permanent data warehouse solution by mid-2017.

Data Analytics will begin with an initial data model of what is currently being collected, and internally developed and supported analytics for NYSDOH use in the first quarter of 2016. A vendor developed analytics suite of tools run against the data stored in the interim warehouse (OHIP DataMart) will be available in November 2016. An enhanced suite of vendor developed

analytics run against the new APD Data Warehouse will be completed by July 2017. As referenced above, full data validation across all payers is expected to be complete by 2018, at which time public data release will be operational.

Given the timing gap for the APC roll out and the fully operational APD, the Innovation Center has devised a plan for an interim solution. It is proposed that the state's Quality Information Office (QIO), IPRO, will function as the interim solution. IPRO has been collecting member level data from health plans for a number of years as part of the Department's annual performance measurement activities. Member level files that include member demographics and numerator status for each measure in the measurement set are submitted for use by the Department. Having the QIO collect APC data falls within the scope of the current QIO contract and therefore will not require a procurement, however, it will require additional funds to be added to the contract. The QIO is currently preparing an assessment of the work and corresponding budget. Additionally, the Department is considering establishing a subcommittee of the Integrated Care Workgroup, including representatives from the QIO, who will explore issues related to attribution, establishing baseline performance, and determine which measures from the APC measurement set should be captured initially.

The interim version of the APC scorecard will only use claims data. For the permanent APC scorecard, NYSDOH is assessing how clinical data captured from EHRs would be used. NYSDOH is currently assessing how clinical quality measures would be sent from the SHIN-NY to the APC scorecard. Currently, three of eight RHIOs are involved in working with providers to help calculate clinical quality measures for different activities. Any submission of clinical quality data from the SHIN-NY would be done in either the QRDA III format or I. RHIOs would send data to the APC scorecard via a direct message or another method determined by the

APC scorecard. Technical resources will be available from the RHIOs and the New York eHealth Collaborative for this purpose

b) HIE 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Convene statewide stakeholder group	Identify, engage, and regularly convene representative stakeholders	SIM Staff	N/A	Promote quality and effectiveness by assuring that 80% of providers utilize HIE and the SHIN-NY	Workgroup established and monthly meetings convened
Promote and ensure provider participation in the SHIN-NY	Promote participation through education; technical supports and assistance as needed	SIM Staff/TA Vendors	N/A	Promote quality and effectiveness by assuring that 80% of providers have access to and utilize HIE	Number of individual practices and providers participating in the SHIN-NY
Secure guidance and input on SHIN-NY	Review draft regulation; evaluate ongoing implementation	SIM Staff /Kuvop, LLC	\$200,000	Develop a targeted workforce strategy to support evolving care delivery model(s)	Ongoing guidance throughout 2016
Secure guidance and input on APD	Review regulations; evaluate ongoing implementation	SIM Team	N/A		Adopt regulations Q2 2016
Secure guidance and input on transparency and confidentiality	External stakeholders consultations to ensure broad acceptance and support of efforts to promote health care cost and quality transparency efforts	SIM Team	N/A	Make health care cost and quality transparent	Set of policy recommendations by Q2 2016

Ensure that data collected are discrete, meaningful, and reliable	As capacities to collect data continue to grow care must be taken to ensure that data collected, shared and promoted is meaningful and purposeful	SIM Team	N/A	Promote efficient use of health care resources	Set of policy recommendations by Q2 2016
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c) Risk Assessment and Mitigation

Lack of Progress on Quality Measures

Risk Identification	Risk Probability	Impact	Overall Priority
Lack of progress in improving quality of care and health outcomes	M	H	H

Mitigation Strategies:

- Publish quarterly metrics.
- Provide early identification and problem solving.
- Build quality improvement capacity at all levels of the system.
- Provide technical assistance where needed for improvement.
- Engage contract compliance mechanisms when necessary.
- Strong stakeholder engagement in all areas, particularly in HIT planning and implementation, APC spread, and multi-payer alternative payment approaches.
- Develop a financing plan to ensure health information exchange efforts sustainable over time.

10. EVALUATION

a) Narrative Summary

SIM resources will be used to fund an external evaluation contractor and will also use traditional project management tools to ensure efficiency, goal attainment and course correction as needed. This evaluator should be on board by the fourth quarter of 2016.

New York is committed to evaluating how best to develop, promote, and sustain innovation. The Evaluation Contractor will utilize a variety of approaches to examine the overall impact of the New York SIM model, the effectiveness of policy and regulatory levers, and determine which program characteristics, implementation approaches or adaptations, and contextual factors are associated with better outcomes and reductions in costs. The evaluation will assess the sustainability of the model to inform work beyond the project period and to inform other states and jurisdictions.

The independent evaluation will ensure that issues are reported to NYSDOH in a timely manner so that NYSDOH can improve the process of health care transformation. The contractor will have the ability to conduct both the broad SIM project evaluation and perform the evaluation of discrete component parts of the initiative including HIT, workforce, access, population health, and value-based payment. In addition to assessing the outcomes related to process and performance measures, the evaluation must also consider measures correlated to patient experience, provider experience, access to care, quality of care, and reduction in the growth of health care expenditures.

The Evaluator must be willing to work with CMS program staff, NYSDOH evaluation staff, and the CMS Federal evaluation contractor for the broad SIM project evaluation. The collaboration with CMS includes sharing both data and methodologies.

The Evaluation contractor will be expected to report results in a timely manner, no less than quarterly, to support rapid cycle evaluation that results in ongoing feedback and adjustments in accordance with evaluation findings. The evaluator will be expected to track and report on model progress that addresses the following:

- a. How the proposed model improves population health, health care delivery and reduces costs;
- b. How the proposed model leverages state regulatory and policy levers;
- c. Methods used to identify providers, provider organizations, and payers participating in the model and to evaluate payer and provider-specific success and challenges;
- d. Identification of all data sources to be used and their relation to proposed outcome measures;
- e. Outline a process for use of NYSDOH data given the multiple available data sets available;
- f. Identification of gaps in available measures and proposals for how best to address identified gaps; and
- g. Outline of a proposal to utilize rapid cycle feedback evaluation reports to improve model performance and meet target milestones for improving health, healthcare quality, and lowering costs.

The Evaluator will work in collaboration with NYSDOH/HRI to develop and implement a self-monitoring program. The goal of this collaboration is to establish the capability and infrastructure to enable the state to develop and sustain rigorous outcome measure driven program self-monitoring beyond the period of the cooperative agreement. More specifically, the State wishes to be able to determine the following:

- I. Is the state achieving targeted PMPM cost trend reductions in while at least maintaining, if not improving, quality and access?
- II. What is the spread overtime of APC by payer including public employees and Medicare?
- III. What is the degree and pace of spread of APC key elements (care coordination and management, outcome-based payment methods, etc.) to payers? Are other payers or populations experiencing cost trend reductions and improvements in quality?
- IV. Which of the key elements, or which combination of key elements, are most strongly associated with success for Triple Aim outcomes? Is there any evidence regarding whether and how community setting, payer, or other contextual differences affect which model elements or combination of elements are most predictive of success?
- V. Does the model implementation lead to changes in service utilization patterns and reduced per member per month, total, medical, and behavioral health care costs?
- VI. Does the model lead to improvements in care coordination and less fragmentation of care and for what populations?
- VII. Does the model lead to improvements in quality and process of care?
- VIII. To what extent does the model improve the level of integration of physical and behavioral health?

- IX. Does the model lead to improvements in member health, well-being and functioning and in reduced of health risk behaviors?
- X. Does the model lead to improved member experiences of care, engagement, and perception of services?
- XI. What factors influence the adoption and spread of model enhancements?
- XII. To what extent are model components implemented consistently and with fidelity?
- XIII. What system, practice, and person-level factors are associated with the model outcomes?

b) Evaluation 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Issue RFP to contract with external evaluator	This RFP seeks a vendor to assist New York State DOH/HRI with development of performance measures, benchmarks, and an evaluation process for the SIM, both overall and by initiative including an evaluation of the mechanisms used to develop and refine the APC delivery model; value based payment and workforce initiatives	TBD	\$674,662	Deliver better care, spend health care dollars more wisely and result in healthier New Yorkers	Monthly reports on progress on goals and objectives

c) Risk Assessment and Mitigation

Overall lack of progress consistent with established milestones

Risk Identification	Risk Probability	Impact	Overall Priority

Lack of progress in transformation and delivery system evolution	M	H	H
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Mitigation Strategies:

- Capture and share lessons learned
- Apply quality improvement practices internally
- Build quality improvement capacity
- Assure access to state leadership, if needed, for gaining additional support or resources needed to accomplish strategic goals and objectives
- Develop an Innovation Center sustainability plan
- Ensure data driven decision making
- Acquire data analytic capacity through hiring highly qualified staff and purchasing software tools needed for complex analyses
- Request assistance from CMMI or other federal agency, if needed
- Publish and disseminate quarterly metrics reports
- Robust evaluation and monitoring of activities
- Strong project management using clear targets for deliverables and timelines
- Strong internal and external communications on project status
- Early identification and resolution of issues and barriers
- Publish quarterly metrics reports
- Engagement of leadership as needed to resolve systems or resource issues
- Engagement with CMMI for technical assistance to resolve issues or barriers

11. POPULATION HEALTH

a) Narrative Summary

New York's SIM is predicated on an integrated care delivery model that is inclusive of and supports linkages between clinical care providers and community-based organizations in order to achieve the goals and objectives of New York's Prevention Agenda 2012-18 ("Prevention Agenda"). The Department's Office of Public Health's activities, programs, and internal and external funding align with and support achievement of the Prevention Agenda goals, and are aligned with the SIM population goals. *Appendix A* describes in further detail New York's population health needs assessment and priority setting, and existing capacity and efforts aimed at population health that are and will be further leveraged in the SIM grant.

In Year 2 of the SIM grant, population health will be promoted in several ways:

- The Department's Prevention Agenda will continue to serve as the state's roadmap to improve population health. In 2016, local health departments and hospitals will prepare their next cycle of local community health improvement planning in conjunction with their community partners. The Office of Public Health (OPH) is updating the five priority action plans to create charts that refocus attention on interventions that are evidence-based or most promising to make an impact. In addition, OPH is identifying process measures, in addition to the existing outcome measures, that can be used to track progress as these interventions are being implemented.
- The Prevention Agenda goals and interventions have been integrated into the State Health Innovation Plan (SHIP) and State's Medicaid waiver, the Delivery System Reform Incentive Payment (DSRIP) program. Under SHIP, many of the APC scorecard measures are directly aligned with the Prevention Agenda measures to ensure that efforts in the community and clinical sectors are working synergistically. *Appendix F*

crosswalks the Prevention Agenda indicators that are measured at the population level with the SIM APC measures that are measured at the practice or managed care plan levels.

- Under DSRIP, Performing Provider Systems (PPSs) were required to submit plans to the state on the implementation of up to 11 projects across the following four domains: Domain 1 – Project progress milestones, Domain 2 – System transformation milestones, Domain 3 – Clinical improvement milestones, and Domain 4 – Population-wide strategy implementation milestones – Prevention Agenda improvements. All DSRIP Project Plans have metrics attached to each Domain. Prevention Agenda goals and indicators were used as the metrics for the Domain 4 projects. In addition, several of the Domain 3 projects align with Prevention Agenda and SIM goals related to asthma, diabetes, cardiovascular disease and behavioral health.
- Practices Transformation (PT) entities will be expected to help primary care practices achieve many of the Prevention Agenda goals by achieving APC capabilities to deliver clinical preventive services and appropriate chronic care management, strengthen community linkages and partnerships to improve delivery of clinical services, increase the use of effective community interventions, such as chronic disease self-management programs and National Diabetes Prevention Programs, and connect patients to resources and supports that can help maintain health.
- PT entities will also assist primary care practices to identify and support activities of the local county Prevention Agenda coalition that is working on community wide strategies to achieve locally selected Prevention Agenda goals. Primary care practices

demonstrating APC capabilities (Gate 3) will be required to participate in regular local level Prevention Agenda calls or activities, as appropriate.

- In Year 2 of the SIM grant, NYS OPH will identify opportunities to further integrate population health activities described in Appendix A into SIM activities. For example, resources developed as part of learning collaboratives, practice facilitation, and community health worker training modules will be shared with the practice transformation entities.
- In our original proposal, we planned to release an RFP to contract with 11 entities to support the work of population health consultants (PHCs). The plan was for these entities, one per region, to be charged with acting as the interface in the community, linking clinical care providers with community-based population health service providers. The intent was that these individuals would enhance, promote, and support clinical-community integration working closely with the practice transformation entities, regional state-funded Population Health Improvement Programs (PHIPs), and Medicaid DSRIP PPSs. While we are still considering this model as a viable option, we are further exploring whether or not this model will have the most impact and be the most efficient use of these funds. We are currently executing a short-term “fact finding” project where we are meeting with key stakeholder groups in the Capital District area of New York State to better understand what resources and connections already exist and what they think is needed to best make the clinical-community linkage. Some of the groups we have already met with or plan to meet with in the next month include managed care organizations, local health departments, a hospital, primary care providers and a PHIP contractor.

b) Population Health 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Continue implementation and local support of Prevention Agenda (PA)	Update PA action plans to refocus attention on interventions that are evidence-based Identify process measures to track progress as interventions are implemented	OPH	N/A	Integrate the PA into NY's health systems transformation efforts	Updated PA action plans and process measures are disseminated to local health departments and hospitals for their community planning by Q2 2016
Maintain/enhance surveillance systems to track population health measures in PA, SIM, DSRIP	Implement BRFSS, expanded BRFSS, and other population health surveillance systems	SIM Team / OPH	N/A	Integrate the PA into NY's health systems transformation efforts	PA Dashboard and metrics are maintained and disseminated, ongoing
Develop supports for APC practices to deliver clinical preventive services and connect patients to community supports	Include specifications regarding TA support for clinical preventive services and population health in Practice Transformation RFP	SIM Team / OPH	N/A	Integrate the PA into NY's health systems transformation efforts	
Facilitate partnerships between local health departments, community organizations and health systems to improve community health	Connect APC practices to local PA coalitions	SIM team	N/A	Integrate the PA into NY's health systems transformation efforts	Primary care practices demonstrating APC capabilities (Gate 3) are participating in regular local level PA calls or activities, as appropriate
Conduct short-term "fact finding" project to better understand local needs to improve linkages between primary care, public health, and	Interview key stakeholder groups including managed care organizations, local health departments, hospitals, primary	SIM team	N/A	Integrate the PA into NY's health systems transformation efforts	Interviews completed and findings summarized by end of Q1 2016

community-based supports	care providers and PHIP contractor				
Issue RFP to meet needs identified in key informant interviews	Contract with entities/individuals	TBD	\$1,826,282	Integrate the PA into NY's health systems transformation efforts	Contracts in place by Q3 2016
Leverage current OPH population health initiatives described in Appendix B into health transformation efforts	Identify highest impact initiatives that can be further incorporated into SIM	SIM Team / OPH	N/A	Integrate the PA into NY's health systems	Ongoing - updates on integration efforts included in quarterly reports

c) Risk Assessment and Mitigation

Risk Identification	Risk Probability	Impact	Overall Priority
Lack of progress in improving key population health indicators	M	H	H

Mitigation Strategies:

- SIM-funded staff will work with Practice Transformation entities and to-be-procured population health contractors to identify barriers to achieving desired population health outcomes. Based on findings, quality improvement strategies will be defined and implemented in coordination with CDC and NYSDOH OPH.

12. WORKFORCE

a) Narrative Summary

New York's robust health care workforce faces future challenges including regional shortages, primary care workforce shortages, hospital downsizing, and an aging workforce. The State will examine the ability of its educational and training institutions to adequately equip its workforce in the networked, team-based, value-driven, primary care focused model of the future.

The State proposes several initiatives to support the new APC model including the following:

1. Identification of clinical and non-clinical gaps and needs specific to primary care, behavioral health, oral health, pharmacy and other areas needed to support the APC model and development of recommendations through a workgroup inclusive of leaders in education and health care.
2. Identification of care manager key competencies and development of a single aligned curriculum to inform practice transformation entities and practices that will increasingly be dependent on care managers to coordinate care and services particularly for persons with multiple chronic diseases.
3. Identification of mechanisms to increase the number of primary care residencies within the State, particularly in primary care Health Professional Shortage Areas.
4. Identification of opportunities to increase the number of active Nurse Practitioners and Physician Assistants working in primary care (currently less than 1/3 of active NPs and about 1/4 of PAs work in primary care).
5. Exploration of scope of practice to assure all health professionals is working at the top of their licenses, consistent with IOM recommendations.
6. Development of tools to increase retention of physicians trained in New York. The State currently retains only 45 percent of all residents trained in the State. New York will work with regional provider networks (teaching institutions, insurers, community health centers, and hospitals) to establish community incentives to recruit and train nurses and residents, promote a diverse provider workforce and address issues of cultural competency and health disparities.

As health care evolves and moves to incorporate innovative care delivery models, a primary goal of the SIM grant remains to ensure a dependable supply of competently trained

professionals. Moreover, having the right size workforce deployed to deliver care most efficiently is a paramount concern of policy makers.

The Workforce Workgroup is comprised of stakeholders ranging from educational institutions to health systems to small provider groups to union and trade associations. In Year 2, the group will continue to drive change by conveying three targeted groups of stakeholders, chaired by external experts, to address:

- Identification of key care coordination functions and regulatory barriers that can impede effective care coordination
- Identification of curricular content for educating the health workforce in core concepts in care coordination (embedded in health professions education curricula and for continuing education of existing health care professionals)
- Identification of recommended core curriculum for training workers in care coordination titles

b) Workforce 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
Convene statewide stakeholder group	Identify, engage and regularly convene representative stakeholders	SIM Staff	N/A	Develop a targeted workforce strategy to support evolving care delivery model(s)	Workgroup established and monthly meetings convened
Convene targeted sub-workgroup to conduct wage and compensation analysis	Conduct analysis and health care worker wages and compensation to inform health transformation needs.	SIM Staff	\$112,252	Develop a targeted workforce strategy to support evolving care delivery model(s)	Provide results of analysis to SHIP and DSRIP stakeholders by Q2 2016

Convene targeted sub-workgroup to define care coordination core competencies	Define common set of core competencies	CHWS	\$125,000	Develop a targeted workforce strategy to support evolving care delivery model(s)	Creation of common definition for sharing with transformation vendors by Q2-2016
Convene targeted sub-workgroup to address Behavioral Health provider shortages	Conduct analysis and develop policy recommendations	CHWS	\$125,000	Improve supply and effectiveness of BH workforce in NYS	Recommendations formalized and presented to Innovation Council Q2 2016
Issue RFP to fund rural residency programs	Provide seed funding to initiate rural residency programs in under-served areas of the State	SIM Team	\$1,000,000	Better distribute primary care workforce to areas of need	Issue RFP and contract Q2 2016
Issue RFP to fund initiatives to retain primary care physicians particularly in under-served regions of the State	Fund model programs to promote retention of primary care providers trained in NYS, to practice in under-served regions of the State	SIM Team	\$300,000	Better distribute primary care workforce to areas of need	Issue RFP and contract Q2 2016
Propose legislation to improve data collection on health professionals in NYS	Improve data availability with which to analyze the number and characteristics of health providers practicing in the State	SIM Team	N/A		Enact legislation Q2 2016 for implementation Q1 2017

c) Risk Assessment and Mitigation

Risk Identification	Risk Probability	Impact	Overall Priority
Inconsistencies across programs in terms of care coordination definition	M	H	H
Continued deficiencies in number of behavioral health providers	H	H	H

Lack of alignment between evolving numbers of primary care providers and need	H	H	H
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Mitigation Strategies:

- Initiate discussions with New York-based medical schools to discuss the potential for curriculum changes
- Work with professional societies to strengthen primary care and behavioral health attraction and retention programs – particularly in underserved regions of the state
- Explore potential for alternative staffing models
- Explore alternative service delivery models to meet need (urgent and retail care)
- Explore emerging telehealth opportunities to address shortage areas

13.ACCESS TO CARE

a) Narrative Summary

In order to understand access to care issues in New York State, an internal Access to Care Workgroup staffed by Department of Health (DOH) and supported by McKinsey consultants, analyzed DOH data, reviewed published literature, and interviewed key DOH staff that had relevant subject matter expertise. This information gathering and analysis focused on better understanding the patient perspective in accessing care and what are their unmet needs.

The internal Access to Care Workgroup centered the analyses on four dimensions that impact access to care that include: Affordability, Availability, Accessibility, and Acceptability. Within each dimension, we further refined the analysis to evaluate access through eight lenses: geographic, socioeconomic, age, racial/ethnic, chronic disease, disability, sexual orientation, gender. Figure 13 shows findings in seven areas.

FIGURE 13: SPECIFIC ACCESS ISSUES

Specific Access Issues: Findings of Data Analysis, Publications and Interviews

Geographic	A North Country, Tug Hill Seaway and Southern Tier have poor access, particularly in terms of availability (primary care providers), and accessibility (distance traveled to care)
	B In New York City, the Bronx, Kings and Queens Counties have overall poor access across multiple dimensions, ranging from coverage to ER utilization
Statewide	D Linguistic barriers to care impact 2.3 million people
	E Serious health literacy barriers associated with low literacy
Specific populations	F Major behavioral health access gaps for children in NYC and the Central regions
	G Pediatric populations in New York City, and elderly populations in in Central New York, Tug Hill Seaway, North Country and Capital regions, have particularly high rates of preventable hospitalization
	H Numerous barriers for persons with disabilities: physical plant and diagnostic equipment; lack of awareness of the range of disabling conditions; clinical and non-clinical knowledge and attitudes, absence of policies and procedures

Once Access to Care issues were identified, additional discussion concentrated on identifying a limited number of key issues and solutions that other SHIP Workgroups were not addressing and that an external Access to Care Workgroup that includes relevant stakeholders, such as providers and advocates for consumers, could provide guidance and recommendations. Three Access to Care issues were selected – transportation to medical appointments, needs of persons with disabilities, and promotion of telehealth. Each of these topic areas is discussed more fully below.

1. Transportation to medical appointments

Many individuals lack the means to get to a medical appointment and require non-emergency medical transportation. These individuals include: residents living on a fixed income such as Social Security Income or Disability Insurance, eligible Medicaid participants who have prior approval from Social Services, and residents unable to afford or access public transportation services in their residential area.

- Explore commercial insurers' coverage for transportation and options
- Review county level and other best practices that have found ways to address

transportation issues

2. Needs of Persons with Disabilities

Nearly 23 percent of adults in New York State have a disability. The most common type of disability of mobility (13.9 percent), followed by cognitive (10.1 percent). There are major barriers to Access to Care for disabled persons: physical barriers (parking, restrooms, entrances, exam tables, diagnostic equipment, transportation), communication barriers (lack of sign language, telephone alternatives, alternate communication methods), and attitudinal/training barriers (stereotypes, biases, provider knowledge about caring for persons with disabilities).

- Promote provider education related to health literacy, cultural sensitivity (e.g. LGBT, ethnic and minority groups) and caring for persons with disabilities
- Review best practices of providers that assess and meet the specific needs of different populations in accessing primary and preventive care, as well as specialty care

3. Promote Telehealth

Telehealth can increase timelier access to primary care and specialty care providers for patients and extend physicians clinical reach to patients. The use of telehealth modalities reduces unnecessary hospital admissions and readmissions.

- Educate health care providers and consumers about the efficacy of telehealth and the existing telehealth reimbursement law
- Educate primary care providers on the effectiveness of home monitoring in managing patients with chronic conditions.
- Consider expansions to the telehealth reimbursement law including definition of originating sites to include patient’s home in select

An external Access to Care Workgroup to advise on these issues will be formed in early 2016. Two to three meetings will be convened on each topic areas. The meeting objectives will include presentations on data and select “best practices” in the state in each topic area, small workgroups formed to debrief on presentation and brainstorm potential recommendations within key areas, small workgroups will provide summaries to larger workgroup, and open discussion to improve ideas and generate recommendations.

b) Access 2016 Summary Table

Core Activity	Description	Vendor	Expected Expenditures	Primary Driver	Metric
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Convene targeted stakeholder subcommittee focusing on telehealth, disability, and transportation	Identify, engage and regularly convene representative stakeholders	SIM Staff	N/A	Assure access to advanced, integrated care delivery models for all without disparity	Workgroup established and meetings convened
Increase telehealth adoption in underserved areas	Implement 2015 telehealth legislation	SIM Staff	N/A	Improve access to care for all New Yorkers without disparity	Implement regulations Q2 2016
Educate consumers to promote health literacy	Develop recommendations to guide consumer education on new care models	SIM Staff/ Communications Contractor	\$348,556.	Improve access to care for all New Yorkers without disparity	Distribution of materials; web publications and other beginning Q2 2016
Evaluate access on 4 dimensions: 1. Affordability	Evaluate affordability in terms of: coverage, premiums, co-pays, and cost transparency	SIM Team	N/A	Improve access to care for all New Yorkers without disparity	Provide policy recommendations to Health Innovation Council Q2 2016
Access on 4 dimensions: 2. Availability	Quantity and distribution of primary, behavioral and specialty services, social services, and convenient hours	SIM Team	N/A	Improve access to care for all New Yorkers without disparity	Provide policy recommendations to Health Innovation Council Q2 2016
Access on 4 dimensions: 3. Accessibility	Timeliness for appointments and wait times; Transportation; and Disability access,	SIM Team	N/A	Improve access to care for all New Yorkers without disparity	Provide policy recommendations to Health Innovation Council Q2 2016
Access on 4 dimensions: 4. Acceptability	Culturally and linguistically appropriate care, awareness of the spectrum of available providers, and self-directed healthcare	SIM Team	N/A	Improve access to care for all New Yorkers without disparity	Provide policy recommendations to Health Innovation Council Q2 2016

c) Risk Assessment and Mitigation

Risk Identification	Risk Probability	Impact	Overall Priority
Access in terms of affordability is not realized	H	H	H
Culturally and linguistically appropriate care is not broadly available	H	M	M
Availability of care is compromised by lack of geographically available services with respect to numbers of providers and to availability of specialty care	H	M	M

Mitigation Strategies:

- Affordability may be impacted by broader systemic changes such as provider and payer consolidation. Efforts to communicate with payers (inclusive of employers) will be key
- Effective communications with consumers to ensure informed use of health care services
- Communication with regulatory bodies to ensure quality and access for all
- Evaluation of primary care payment models to ensure long – term savings are shared by all
- Communications with local community-based organizations able to provide education and training to ensure culturally competent service provision
- Communications with health care educational institutions and professional associations to develop long-term plans to address and meet underserved areas

C) GENERAL SIM OPERATIONAL AND POLICY AREAS

C1. SIM Governance, Management Structure and Decision Making Authority

(See section B1 above)

Executive decision-making rests with the Governor’s Office Deputy Secretary for Health, Paul Francis, JD, in collaboration with State agency officials, including Department of Health

Commissioner, Howard Zucker, MD, JD, and the Deputy Superintendent for Health, Department of Financial Services, and the Medical Director at the Office of Mental Health. The State Health Innovation Council is jointly chaired by Dr. Zucker and Mr. Francis, which, as previously noted, governs the global direction for the SHIP and the alignment between its concurrent initiatives.

C2. Stakeholder Engagement

The overarching Health Innovation Council, coupled with its subsidiary workgroups Integrated Care, Workforce, Health Information Technology, and Access, are, by design, capturing the broadest possible coalition of voices from across New York State. To further ensure collaboration between government and external stakeholders, each of these committees is co-chaired by an expert from outside state government. Throughout plan year two, these groups will continue to convene and provide oversight, objective review, and direction for the SHIP.

Additionally, the Innovation Center has engaged the Northeast Business Group on Health (NEBGH) to continue its work of direct informational sessions on the goals of SHIP across the state. These 16 meetings were conducted regionally and included representation from providers, payers, employers, and consumer groups.

The Innovation Center has sought responses to craft and deliver a statewide communications plan that aims to reduce the public's confusion surrounding the overlap of SIM, DSRIP, CPCi, and TCPI. This was a key and central finding of stakeholder feedback from communities around the State.

C3. Plan for Improving Population Health

(See section B7 above)

C4. Healthcare Delivery System Transformation Plan

New York’s health care delivery transformation plan, as articulated in the SHIP, is built on five pillars and three enablers.

FIGURE 14: PILLARS AND ENABLERS

Goal	Delivering the Triple Aim – Healthier people, better care and individual experience, smarter spending				
Pillars	1	2	3	4	5
	Improve access to care for all New Yorkers, without disparity Elimination of financial, geographic, cultural, operational barriers to access appropriate care in a timely way	Integrate care to address patient needs seamlessly Integration of primary care, behavioral health, acute and post-acute care, and supportive care for those that require it	Make the cost and quality of care transparent to empower decision making Information to enable individuals and providers to make better decisions at enrollment and at the point of care	Pay for health care value, not volume Rewards for providers who achieve high standards for quality and individual experience while controlling costs	Promote population health Improved screening and prevention through closer linkages between primary care, public health, and community-based supports
Enablers	Workforce strategy	A	Matching the capacity and skills of our health care workforce to the evolving needs of our communities		
	Health information technology	B	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation		
	Performance measurement & evaluation	C	Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation		

The SHIP, recognizing that a lasting health delivery system reform requires a high performing primary care system, proposes statewide implementation of an enhanced medical home model, “Advanced Primary Care” (APC). It also recognizes that coordination and integration of ongoing initiatives is key to long-term success.

Findings in New York and nationally suggest that a system with a medical home model at its heart will achieve the Triple Aim. Thus, New York is proposing initiatives to create more

rational, patient-centered care for all New Yorkers. SIM funding, predicated on the overarching vision as articulated in the chart above, is requested to support the following:

1. APC model implementation through targeted practice transformation support;
2. Programs to ensure an adequate workforce;
3. Creation of a common scorecard to align measures across payers and providers; and
4. Population health initiatives to align clinical care and CDC- and PA- endorsed strategies.

New York has led the nation in the adoption of the medical home model and the APC model builds on the State's strong base. As of July 2013, nearly 5,000 clinicians (25 percent of total primary care physicians) in New York were working in practices recognized by the National Committee for Quality Assurance (NCQA) as PCMHs. Federally Qualified Health Centers in New York have achieved notable success with 80 percent of FQHC networks having achieved some level of PCMH certification. However, three-quarters of all primary care practitioners in the state work do not yet work in PCMH recognized practices. SIM represents an opportunity to leverage investments made to date to assure broad adoption of an APC model inclusive of behavioral and population health, coupled with a strong workforce and educated and engaged consumers, supportive payment and common metrics. Specific goals for delivery system reform are detailed below:

A. Promotion and Implementation of Advanced Primary Care

New York's Advanced Primary Care model, developed in concert with payers, providers, and consumers, is constructed in term of a defined set of practice capabilities that, in turn, indicate a practices' achievement of milestones and "Gates" that are used to determine payment. Practice capabilities are defined in Figure 15 below:

FIGURE 15: PRACTICE CAPABILITIES

Category	Description
Patient-centered care	<ul style="list-style-type: none"> Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	<ul style="list-style-type: none"> Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/coordination	<ul style="list-style-type: none"> Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	<ul style="list-style-type: none"> Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	<ul style="list-style-type: none"> Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	<ul style="list-style-type: none"> Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	<ul style="list-style-type: none"> Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

All practices will be evaluated in terms of meeting these capabilities and in terms of meeting a series of milestones and in turn one of three Gates as follows:

Gate 1: Commitment. What a practice achieves on its own, before any SIM and payer-supported TA is provided. The practice must complete an initial self-assessment and enter into an agreement with a TA provider to participate in the program. Practices must show evidence of commitment to change as demonstrated by the allocation of appropriate resources and personnel. A shared responsibility between payers and providers in the region is needed to ensure that payers participating in (financially supporting) APC represent a “critical mass” of the practice’s panel. This includes having a plan for collecting and reporting non-claims based core measures.

Payment: SIM-funded TA and payer funded transformation support to compensate practices for lost revenue due to time and effort spent on practice transformation.

Gate 2: Readiness for Care Coordination. Following one year of transformation support, practices will be expected to be ready to provide care coordination for attributed patients.

Payment: Payers would at Gate 2 begin to pay practices for care coordination, likely as a PMPM payment and, at minimum, eligibility for upside-only risk-sharing outcome-based payment.

Gate 3: Demonstration of APC capabilities and performance. One year after meeting Gate 2 (or sooner if ready), practices will have to demonstrate active care management and coordination for a majority of their high-risk patients. At this point, they will have to be connected to their regional health information exchange (RHIO). Importantly, demonstrating APC capabilities implies moving from an ability to measure performance to demonstrated improvements in quality and experience, and reduced costs. APC practices will have to continue to meet defined performance targets after passing Gate 3 in order to remain in the program.

Payment: Continued care coordination payments, and, at minimum, eligibility for upside risk sharing.

Timeframe for implementation of the above is as follows:

1. Issuance of competitive procurement to select and fund Practice Transformation Technical Assistance Entities to work with practices throughout New York State.
2. Issuance of a competitive procurement to fund an Independent Oversight Entity to ensure practice compliance with established standards for purposes of general oversight and to inform health care payment. (January 2016). Discussions with payers resulting in identification of a need and desire for an independent entity to

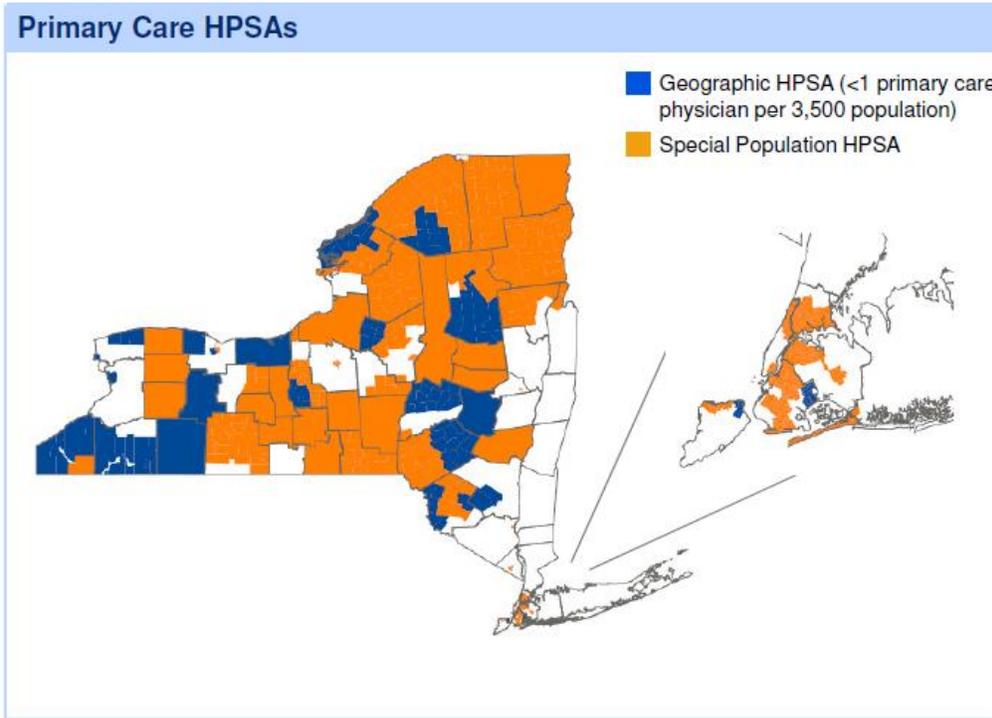
audit and certify to payers that practices have achieved milestones that warrant payment (practice transformation support, care coordination payment, and ultimately outcome based payments). To that end, a competitive procurement to identify such an entity is in the process of being drafted and should be complete in January 2016.

3. Decisions on competitive procurements are anticipated to be finalized during Quarter 2 of 2016 with contracts executed July – August 2016.
4. Practice Transformation entities begin working with practices September – October 2016.
5. Multi-payer APC Performance period beginning January 2017.
6. Common Scorecard Implementation
 - a. Finalization of scorecard architecture to guide data submission Q2 2016
 - b. Scorecard design and production planning
 - c. Scorecard roll-out December 2016

B. Workforce

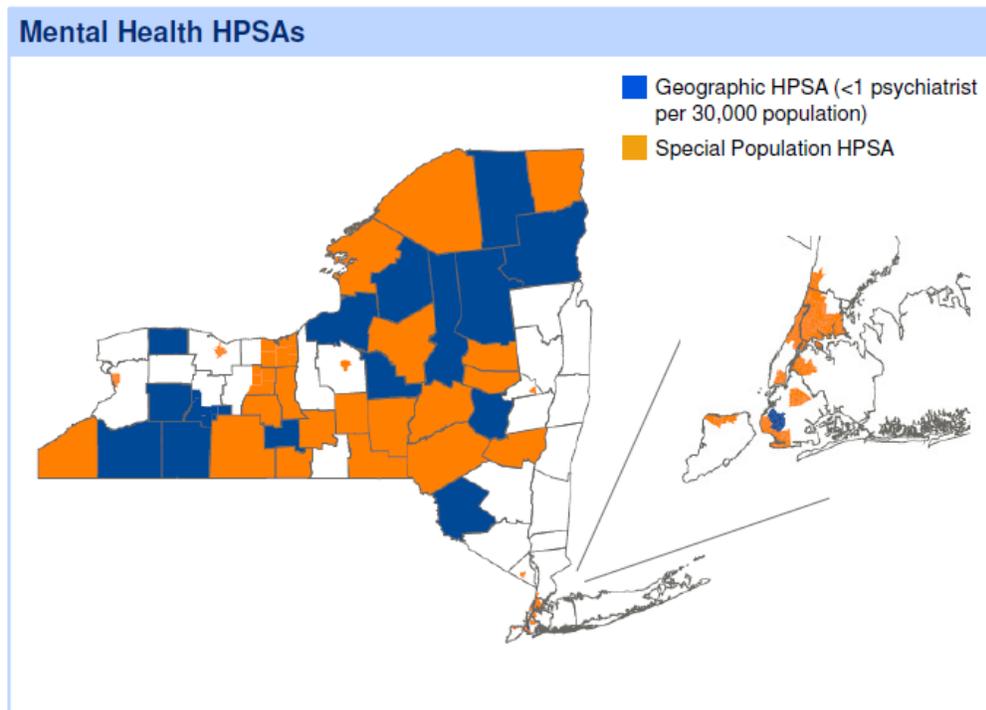
As demonstrated by Figure 16 below, New York has a chronic maldistribution of health care workers. These shortages are particularly pronounced in primary care. To mitigate these disparities, the State will use SIM resources to fund two targeted initiatives: the Rural Residency program and a Physician Retention program.

FIGURE 16: DISTRIBUTION OF PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS



Source: Center for Health Workforce Studies; HRSA

Distribution of Mental Health HPSAs



Source: Center for Health Workforce Studies; HRSA

Physician Retention. New York State has a significant and long-standing problem of physicians leaving the state after completing their medical training, as well as problems getting physicians to select primary care as their specialty and work in underserved rural and inner-city areas. This initiative would test model(s) to increase the retention and recruitment of physicians to work in medically underserved regions within the state, particularly targeting physicians who are completing their residency training in New York. \$500,000 in State Innovation Model (SIM) funding is available to award an organization(s) of health care providers/practitioners, teaching institutions, or a network that represents health care providers/practitioners, or teaching institutions to develop innovative model(s) to provide exposure to physicians and medical residents on opportunities available to practice medicine in medically underserved regions. Physicians and medical residents will be given the opportunity to visit communities in New York State, learn about health care facilities and resources, talk to local practicing physicians and health care administrators, and learn about social, recreational, educational, and cultural activities available in the various communities in the state. Participating organizations will be required to evaluate short and long-term program outcomes and serve as a resource for other organizations interested in replicating the model(s) in other regions or states.

The Rural Residency Program grant is limited to three years and shall be used to assist applicants in procuring the infrastructure needed to develop accredited new or restructured GME programs serving rural communities in New York State. The key purpose of the Rural Residency Grant is to have a new or restructured rural GME program by the end of the grant period. Applicants, sponsoring institutions, and partners must demonstrate the capacity to develop and implement an accredited program that reflects the healthcare needs of the rural

community and recognizes the importance of a residency curriculum and experience that teaches the skills needed to practice in the changing health care environment.

It is expected that grantees will form strong partnerships with local resources to facilitate implementation and sustainability of the programs with the goal of retaining trained physicians in the rural practice setting. Joint planning between hospitals, sponsoring institutions, non-hospital training sites, and other community stakeholders should occur to address the feasibility of implementing the rural GME program and to identify and address key issues associated with its implementation.

C5. Payment And / Or Service Delivery Model Innovation

Implementation of the Advanced Primary Care Model is predicated on a practices' evolution to a core set of capabilities that are inclusive of patient centered care, population health, care management and care coordination, assuring access to care, use of HIT, a core measure set and participation in payment model that incepts quality and performance.

Implementation will take place through a sequence of events as detailed below that include issuance of competitive procurements to identify and fund contracts to provide practices transformation assistance and to audit those practices as independent agents that will report both to the state and to the individual payers.

1. Issuance of a request for information by the Department of Financial Services to secure information on current alternative payment models and to assess level of future interest in and commitment to an aligned approach to payment for Advanced Primary Care (January 2016).
2. Multi-payer agreement on payment for advanced primary care (January – March 2016).

3. Release of rate review submission guidelines inclusive of information related to advanced primary care (March 2016).
4. Rate review evaluations and refinement of payer APC models (June 2016).

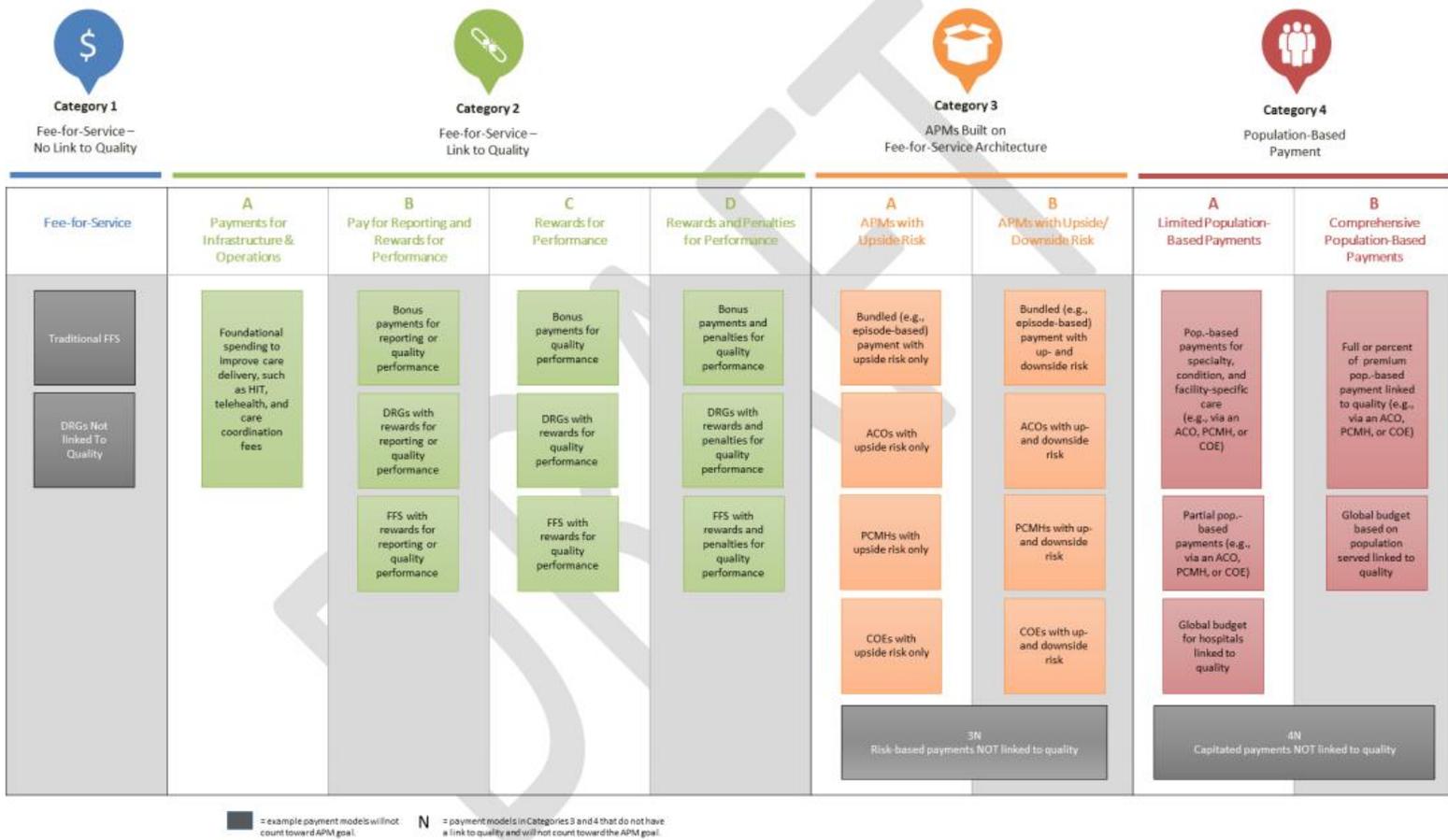
APC payments are anticipated to include care coordination fees (at Gate 2) evolving to outcome based payments that include the potential for up and down side risk sharing that incents both quality and value (Gate 3). The payment models, aligned with Gates as described above and on *Appendix J: APC FAQs*, align with both the New York State DSRIP VBP model (see Figure 17) and the HCPLAN payment categorization (see Figure 18).

FIGURE 17: New York State DSRIP VBP MODEL

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

FIGURE 18: HCPLAN PAYMENT CATEGORIZATION

Figure 3: DRAFT APM Framework



C6. Leveraging Regulatory Authority

The New York State Department of Financial Services and the Innovation Center are looking at various possible regulatory and policy levers to incentivize adoption of the APC and other value-based contracting (not related to primary care). These levers include:

- DFS’s prior approval authority: work with stakeholders to develop metrics to recognize issuers’ investments in APC and increased percentage of APC contracts across their

entire book of business, working towards the goal of 80 percent of the population having value based coverage.

- Network adequacy: we are considering whether network adequacy review could include criteria related to APC contracts and other value based contracts. This would help the state achieve its goal of 80 percent value based coverage.
- DFS's policy form review: work with stakeholders to develop standard value based insurance design and benefits designs to promote the state's goal of 80 percent value based coverage.

With respect to Health Republic, their dissolution has caused approximately 200,000 former Health Republic members to seek coverage with new issuers. This will create a certain amount of disruption in the market in that issuers' 2016 premium rates did not include the risk associated with former Health Republic members that are enrolling in the new issuer's plans. Issuer's will have to make adjustments in 2017 rates to account for former Health Republic members, which may be a factor in discussions about encouraging investments in the APC model, practice transformation payments or care coordination payments.

C7. Quality Measure Alignment

1. Common Scorecard

During 2015, multiple ongoing efforts were undertaken to work with providers, payers and consumers to identify a common set of measures that address quality, utilization and cost in a succinct but meaningful manner. As a first step numerous existing measure sets were cross-walked to identify common measures. From this set, efforts were made to further refine based on the following measure characteristics.

The resulting measure set was presented at both formal Integrated Care Workgroup meetings as well as a numerous one on one discussions with payers, providers, and consumers. The final measure set includes measures that can be derived from claims data as well as measures from electronic health records. Full implementation of the common scorecard is predicated on a fully functioning APD that is well integrated with New York's SHIN-NY. Given developmental timelines for both of these initiatives, the State has developed both a long-term and an interim solution to data collection to ensure timely implementation of the APC model. Each are described below.

Common Score Card Long - Term Solution: The All Payer Database (APD) is a comprehensive database of all health claims for all New Yorkers, including enrollees of Medicaid, Medicare, and commercial health plans. The All Payer Database will be the source of data for APC measurement in the future, but the projected date for reliable, complete APD data is mid-2018.

Engagement in the APC model by payers is scheduled to begin in 2016, so an interim data collection plan needs to be developed.

Interim Solution: The interim solution is proposed to build off existing software developed by IPRO, New York's External Quality Review Organization. IPRO has built a data collection tool for the collection of the Quality Assurance Reporting Requirements (QARR) data from Medicaid and commercial health plans in New York. This tool collects measure summary data at the plan level, but also includes a data set called the "member-level file", a data set that includes de-identified patient-level data across all measures. For example, this tool will report for each plan, their summary mammography rate for women, with simply a numerator and denominator. In addition, if the denominator was 400, there will be a dataset with 400 lines of data denoting

whether each enrollee got the service (mammography) or not. QARR is based on the Healthcare Effectiveness Data and Information Set (HEDIS), a national quality measure set. Calculation of these measures is typically done by a HEDIS certified vendor, vendors that have adhered to a strict set of criteria to insure reliability and consistency of the data reporting. All of the certified HEDIS vendors can produce reports at the summary level, or at the patient level (member-level file).

The current IPRO data collection tool for QARR reporting will be augmented by 1) information on the attributed PCP and 2) mapping of PCPs to a practice or clinic. Payers will need to link the member-level quality information, the attributed PCP and corresponding practice together and will be responsible for collecting these measures (quarterly, annually) for APC.

High-level design specifications include the following:

- A minimum of ten measures for the scorecard
- Numerators and denominators for claim-based measures to be provided by payers
- Practice level and plan specific measures based on aggregating payer measures at the provider/site level
- Performance comparisons to be compared with a baseline where feasible and/or in comparison with external benchmarks (for HEDIS measures) and
- Individual practice reports with measures at the practice level

The APC Common Measure Set timeline can be found in Figure 10.

C8. SIM Alignment with State and Federal Initiatives

New York State Innovation Center staff work closely with state and local entities on implementing similar or aligned health system and payment reforms. Two significant, related

initiatives include New York's Medicaid DSRIP and the CMMI-funded Transforming Clinical Practice Initiative (TCPI). It is essential that these initiatives be well coordinated from both the state and federal perspectives. To the extent that inconsistencies exist or there is a lack of clarity among payers or providers, the overall effectiveness of all initiatives will be diminished.

Discussions are ongoing to develop mechanism to align and integrate SIM with both DSRIP and TCPI with respect to implementation of the Advanced Primary Care model. To that end, the NYS DOH is organizing a NYS Practice Transformation Coordinating Council (PTCC) to bring together the leaders of these initiatives on a regular basis, to coordinate their efforts, and – to the degree possible and permitted, to develop unified approaches to the conduct of their work: common practice assessments, the same or similar expected competencies, curricula and milestones, and as much as possible, common measure sets. In terms of DSRIP, discussions are ongoing in terms of how achievement of NCQA PCMH 2014 (and DSRIP goal) is consistent with Gate 2 under the APC model. SIM APC and TCPI alignment is being promoted through the following:

- Creation of a single or aligned practice assessment tool;
- Development of a unified data base to ensure that all practices are accounted for, to promote coordination and ensure there is no duplication of effort; and
- Adoption of a consistent or aligned curriculum to assure that all practices evolve to achieve the competencies needed to provider effective care coordination and an ability to be reimbursed using an alternative payment model that incents and promotes quality and value.

As noted earlier, a clear, cohesive, and comprehensive communications strategy will be required to ensure clarity on the part of payers and providers alike. To that end, with SIM-

funding, the State is in the process of procuring a communications entity to assist the Innovation Center's work.

The DSRIP initiative clearly notes that achievement of APC is sufficient to meet DSRIP Performing Provider System (PPS) requirements. Coordination with Medicaid is critical. The State's Medicaid program is the single largest health insurance program in the state, spending more than \$54 billion annually to provide health care to more than 6 million eligible individuals. Effective April 10, 2014, CMS approved New York's request for a Medicaid waiver amendment to the existing 1115 Partnership Plan. The centerpiece of the waiver amendment is the creation of the DSRIP Program which seeks to reduce avoidable hospital use and emergency department use by 25 percent over the next five years, move to a more integrated care delivery system that includes the APC model, and move away from fee-for-service – components that align well with and will be integrated with the New York State SIM initiative.

Other related initiatives that both inform and will be transitioned to be aligned with the SIM models' goals are CPCi in the Hudson Valley of New York and MAPCP in the Adirondack region. Work to ensure consistency and alignment with ACOs is ongoing. It is estimated that 20 percent of New York's primary care providers (PCPs) are within ACOs working within approximately 1,000 ACO-affiliated practices. Criteria for ACO PCP eligibility for SIM-funded practice transformation are currently being explored and will be finalized as part of the forthcoming Practice Transformation procurement in Q4 2015.

FIGURE 19: MEDICAID AND DSRIP APC ALIGNMENT

Medicaid and DSRIP programs are largely aligned with APC

- **Will Medicaid expect all Medicaid primary care practices to participate in APC?**
 - *PPSs PCPs must become 'PCMH (NCQA 2014) or APC'. At this point participation in APC specifically is not required.*
- **Will all Medicaid primary care practices receiving the PCMH NCQA 'bump' be expected to eventually participate in APC in order to continue to receive the 'bump'?**
 - *The PCMH NCQA 'bump' today has no conditions for performance, but in the future these practices will likely have a performance requirement. Consistent with APC, this may take the form of successfully passing Gate 3 within one year and meeting performance requirements, otherwise the PCMH NCQA 'bump' will cease.*
- **How will Medicaid measure performance in primary care?**
 - *Medicaid primary care practices will increasingly be measured using the APC core measure set. For those practices involved in chronic bundles, there will also be bundle-specific measures.*
- **How will Medicaid support practice transformation?**
 - *Medicaid primary care practices part of PPSs will receive DSRIP payments to support their transformation toward NCQA (which earns them APC Gate 2) or toward their transformation to APC Gate 2 without NCQA.*
- **What kind of outcomes-based payments will be available for primary care?**
 - *Medicaid primary care practices will have flexibility to choose from the VBP roadmap (Level 1 and above), including the option of doing chronic bundles or a professional-led ACO. Being an PCMH NCQA or APC will not be a requirement for entering VBP arrangements.*

C9. Workforce Capacity Monitoring and Reporting

(See section B8 above)

C10. Health Information Technology

(See section B5 above)

C11. Program Monitoring and Reporting

(See section B6 above)

New York is committed to accountability and transparency. Starting with Q1 2017, New York intends to publish a quarterly, statewide multi-payer performance report with quality measures, utilization statistics, and expenditure trends, if available, by major payer category.

After the first publication, future editions will be structured to show changes over time. The multi-payer report will include baseline data for interim measure set.

The Innovation Center will be responsible for rapid cycle learning through multiple methods including learning collaborative, technical assistance and coaching, as well as through dissemination of successful reforms and innovations. The Innovation Center will engage clinicians, providers, and health plans along with health systems staff, and others to understand what new processes and new innovations are being implemented. Learned best practices will be shared to ensure broad community engagement. In addition, the center will provide data and research on external innovations by sharing expertise and input regionally and nationally on the best evidence-based practices and innovations in quality and payment that will facilitate improvement on problems that have been identified.

Moreover, the Innovation Center has and will continue to publish a monthly newsletter highlighting pertinent research from around the state and nation and to share state-specific research, reports, and findings.

C12. Data Collection, Sharing, and Evaluation

(Also see section B6 above)

Reporting to Practices: The New York SIM initiative will implement data collection, sharing and evaluation through a variety of phased initiatives. The State's All Payer Database is targeted to become fully operational during the fourth quarter of 2017. To assure smooth and timely implementation of SIM APC, and to create a live test case for the APD, an interim data solution is being explored. This data solution will rely on reporting of existing claim-based

metrics only to be reported through the State's QIO for aggregation (numerators and denominators only to start), attribution and conveying back to providers to support practice-wide, payer agnostic reporting of key quality measures, as defined in the set of core metrics described earlier.

The APC measure set will be launched in July 2016 for those practices opting to participate as a first wave with an APD support scorecard (using similar metrics to assure consistency) launched in Q1/2 2017. The final score card will include 20 measures, while the initial or interim score card will include 8-12 measures as version 1. Still under consideration is the collection of a few clinical e-measures (as a beta test) including items such as colorectal screening, controlling high blood pressure, and depression screening and management. Design specifications under final review and discussion include: underlying data source, unit of measure (practice, plan, etc), performance comparisons, attribution information, user type, reporting frequency, and user support. These design elements are expected to be finalized during Q4 2015.

When complete, New York's APD will be a centralized and coordinated source of claims data inclusive of all payers and eventually of population health metrics to ensure a comprehensive source of data with which to evaluate programs, including SIM, to target resources and focus policy. New York's APD will provide a robust dataset that will support a variety of uses. A few of the potential uses of the APD include:

- Health Care Transformation - To evaluate care delivery and payment models and identify quality improvement opportunities to avoid waste, over-under or misuse of treatments, as well as conflicting plans of care.

- Comparative Effectiveness - To research the effectiveness, benefits and harms of various treatment options. This will be used to inform healthcare decisions for policymakers, payers, providers and consumers.
- Strengthening Public Health Practice and Improving Population Health - To monitor health status and identify community health problems, including health disparities, detect and investigate health problems and health hazards in the community, and evaluate effectiveness, accessibility and quality of public health services, strategies and programs.
- Health Care Resources Needs Assessment - To support planning and identify resource needs to improve disease prevention and ensure the provision of effective diagnosis, treatment, and rehabilitation services.
- Risk Adjustment Under the Affordable Care Act - To collect data necessary for New York to make the risk-adjustment calculations required under the Federal Patient Protection and Affordable Care Act (ACA).
- Premium Review to Support the Prior Approval Law and Additional Insurance Regulation Activities - To enhance and expedite the ability of Health Plans and regulators to prescribe and determine the appropriateness of premium rates. For example, to identify underlying cost drivers for premiums, as well as regional variations in premium rates, and establish policies for risk adjustment.
- Improving and Enhancing Premium Rate Review – New York’s robust APD will be leveraged to synthesize quality, patient safety, and cost and efficiency metrics to better inform premium rate review activities. Integrating quality and efficiency measures as a key component of rate review is essential to promote value as measured by quality and efficiency. A comprehensive data set inclusive of quality and efficiency measures for all

New Yorkers will allow and support evaluation and comparison of the relative value of insurance products offered to all New Yorkers.

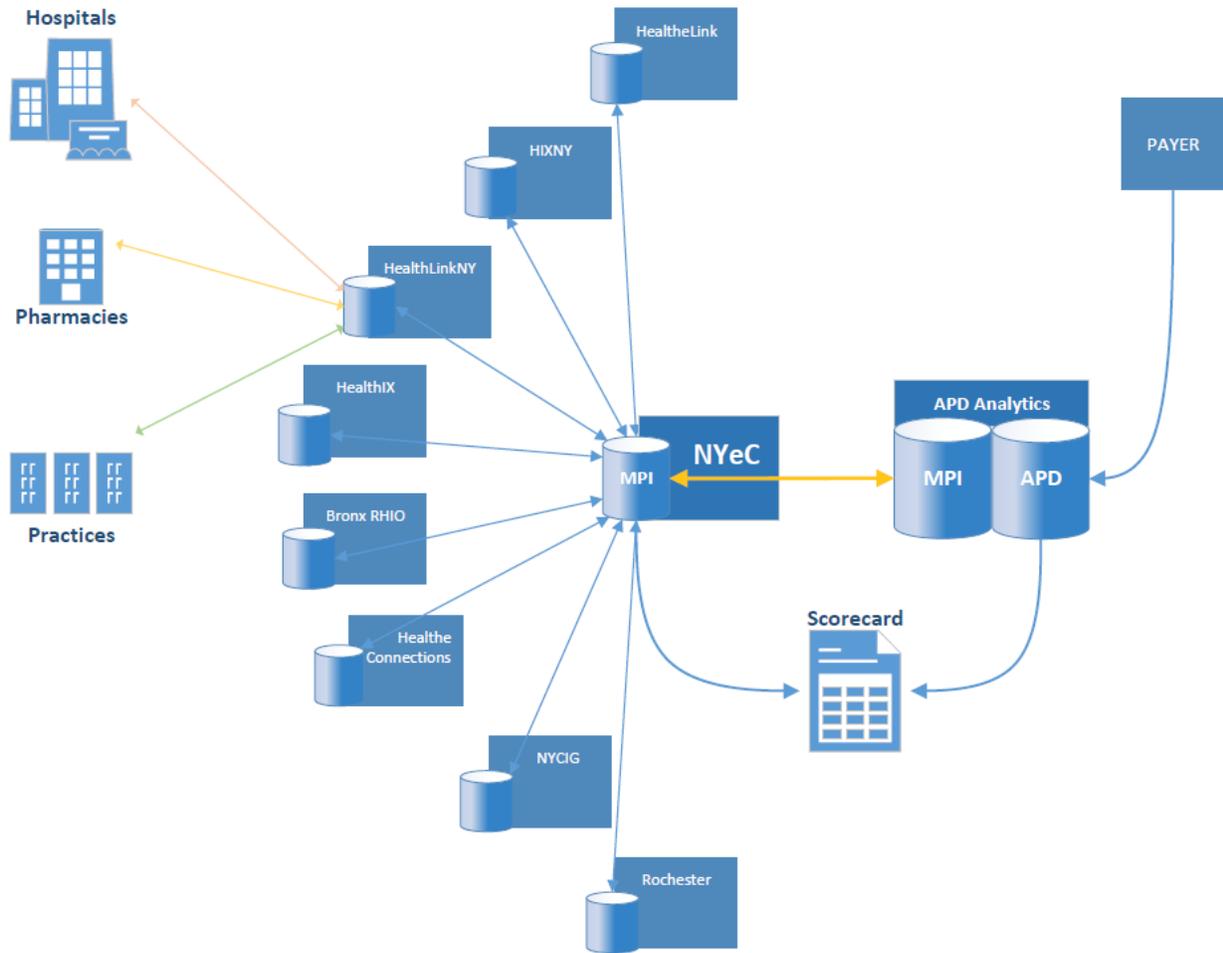
- Enhancing Consumer Protection Standards Through Publication of Health Pricing Data – New York will be able to provide consumers high quality, informative statistics on which to base health care coverage decisions.

Ongoing public health reporting mechanisms will continue to inform the SIM with a vision toward long term integration. Among these existing data bases are:

- The State Prevention Agenda Tracking system
https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/
- The Behavioral Risk Factor Surveillance System (BRFSS) - an ongoing survey which monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population.
- The Statewide Planning and Research Cooperative (SPARCS) - a comprehensive all payer data reporting system established in 1979 that collects patient level on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit, and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services. This rich data source will be incorporated as part of the State's APD when fully functional.
- Vital Records - a rich source of data for births and deaths that occur in New York State outside of New York City and for marriage licenses issued in New York State outside of New York City. Also on file are divorce records for all of New York State since 1963.

- As part of its plan for Federal Fiscal Year 16, the SHIN-NY will begin a planning process to identify specifically how the SHIN-NY will connect to the APD. As described in Figure 20, the New York eHealth Collaborative (NYeC) and each RHIO maintain master patient indexes which allow patients to be matched and queried across organizational entities. Similarly, a connection would be made between a Master Patient Index to be built in the APD and the NYeC statewide MPI. NYSDOH has received approval for its HIE IAPD update for FFY2016. One activity in the approved IAPD-U is the technical planning for connecting the SHIN-NY to the APD.

FIGURE 20: SHIN-NY & APD Connection



Program Reporting - Innovation Center staff are charged with creation of Gantt charts for each of the topical workgroups and for the Initiative as a whole. We will use these charts to guide weekly meetings, to post to the department’s website for broad consumer and external stakeholder information, and for sharing with CMMI.

C13. Fraud and Abuse Prevention, Detection, and Correction

SIM staff will use the following methods to assure fraud prevention and detection:

- A small team of core staff, including Contract Administrators and program staff, will proactively manage vendor contracts requiring at least weekly contact with vendors. These staff will provide overarching guidance and technical assistance to vendors, review all documentation submitted by the vendors to substantiate claims made on invoices to ensure changes are appropriate and valid, audit the quantity and quality of assistance provided by maintaining contact with practices being served by vendors and serve as the link between providers, PT vendors and the Director of Project Management for SIM grant activities in New York State.
- The contract management team will be using a tiered and role based (program and financial) review process where multiple staff will review invoices and multiple signatures in a linear order are necessary to submit an invoice for payment.
- A third party evaluator will be substantiating the claims made by PT entities through site visits and data reviews, and verification of submitted documentation about practice enrollment or Gate assessments.
- If a vendor is shown to have made erroneous charges, we will withhold payment from future vouchers as a method of recoupment (payment will be issued on a 30 day lag). If an intentionally fraudulent charge is made, the contract will be terminated, funds withheld, and if necessary, begin a legal recoupment process to ensure to the extent possible, that all fraudulent funds are recouped and reinvested in the SIM.
- There will be coordinated efforts with staff in areas coordinating other initiatives like TCPI and DRSIP. These programs will provide a report of entity and practice enrollment information that SIM staff will use a check against double charges and other possible overlap of funding to ensure no fraud is taking place.

EVALUATING PROBABILITY, IMPACT AND RISK PRIORITY

New York's Advanced Primary Care model requires multi-payer and multi-provider delivery and payment systems change and therefore must, to ensure success, be coordinated across numerous levels of government and agencies including collaboration with Medicare, Medicaid (insuring over 6 million New Yorkers), the State Department of Financial Services (responsible for oversight of commercial insurers), the State Office of Mental Health, the Department of Civil Service (administrator of health benefits for state employees), and the New York State Executive Chamber. The Innovation Center is constructed as the hub to coordinate project activities. Each area has an identified project area lead responsible for communicating and coordinating activities. Large group and topic-specific workgroup meetings are convened weekly as well as ongoing communications with external stakeholders and SIM-funded consultants. These meetings provide a forum for updates and share progress, identify barriers and develop solutions. Below, we discuss our risk probability, impact and overall priority matrix across the major areas of our SIM project and our proposed mitigation strategies.

Overall likelihood of success

The Advanced Primary Care model has broad support from stakeholders, executive leadership, and CMS. The model also has Medicaid's approval as indicated in the State's DSRIP Terms and Conditions which explicitly note APC as possible and acceptable primary care delivery model for purposes of fulfilling the Terms and Conditions. In addition, New York has secured strong support for the model through the extensive work of consultants and communication with payers, providers, and consumers. Throughout the development year, 2015, New York State convened regional stakeholder forums throughout the state reaching major payers in each region, regional health collaborative, business groups, and providers. During

these sessions, the need for change, background on APC and value based primary care, core measures and anticipated outcomes were shared for input, guidance and recommendations. Overall, there was consistent support for the proposed model, yet, simultaneously, concern with the pace of change. New York will continue to engage stakeholders as the APC model is rolled out and implemented to monitor this sentiment. As previously noted, group and individual meetings with health plans operating in New York have taken place or are scheduled to take place. The health plans include: Capital District Physicians Health Plan, United Health Care, Emblem, HealthNow, Independent Health, Empire BC/BS/Anthem, Cigna, MVP Health Care, Aetna, and Excellus.

It is incumbent on the Innovation Center, through the practice transformation funds allotted in the SIM grant, to achieve the above. While many obstacles remain, a key metric of success will be in building regional alignment by and between payers. This alignment, in the form of remuneration to practices to change the way in which they operate, in order to be effective, must reach a critical mass of approximately 60 percent of payers in any single region. To spur this coordination and transformative change, the Department of Financial Services has regulatory tools available to either incent or compel participation in the APC model of care through its role as regulator. Given our lofty goals, the intent, however, is not to compel but to incent participation through favorable adjustments such as the medical loss ratio (MLR)

Appendix

Appendix A: OMITTED

Appendix B: Population Health

1. State health needs assessment and priority setting

Population health in New York (NY) is guided by the State's Prevention Agenda 2013-2018. The Prevention Agenda was developed in 2012 by the Department of Health and a committee made up of a diverse set of stakeholders including local health departments (LHDs), health care providers, health plans, community-based organizations, academia, employers, state agencies, schools and businesses. The Prevention Agenda has five priorities: (1) Prevent Chronic Disease; (2) Promote Healthy and Safe Environments; (3) Promote Healthy Women, Infants and Children; (4) Promote Mental Health and Prevent Substance Abuse; and (5) Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare Associated Infections.

Each priority area has an action plan that identifies goals and indicators to measure progress and recommended policies and evidence-based interventions using the National Prevention Strategy, Guide to Community Preventive Services, and other sources. The action plans include interventions in all five tiers of the Health Impact Pyramid, highlighting the importance of activities across the spectrum of community and clinical settings. Interventions and activities are also delineated by stakeholder groups so that each sector can identify evidence-based or promising practices they can adapt for implementation to address the specific health issues in their communities. Additional information on the Prevention Agenda can be found at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

The Prevention Agenda served as a guide to LHDs as they developed their mandated Community Health Assessments, which included a Community Health Improvement Plan for 2014-2017, and to hospitals as they developed mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act. LHDs and hospitals were asked to collaborate with each other and community partners on the development of these documents and to identify at least two priorities from the Prevention Agenda. For each priority, LHDs and hospitals identified goals and objectives, improvement strategies and performance measures with measurable and time-framed targets over the plan period.

2. Existing capacity and efforts aimed at population health

Public health surveillance

The Office of Public Health (OPH) has conducted periodic expanded Behavioral Risk Factor Surveillance System (eBRFSS) to collect county-specific data on key population health indicators. The eBRFSS has been conducted in 2003, 2008-09, and 2014-15, and is planned for 2017 and 2019. The annual BRFSS and eBRFSS are supported by a combination state and federal funding. The State's Medicaid Program has directed significant funding to support BRFSS and eBRFSS, recognizing the importance of population-level data in tracking progress of both DSRIP and SHIP.

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

https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard

Integration of population health with other DOH initiatives

OPH has staff representatives on all SIM and Medicaid Reform (DSRIP) workgroups (e.g., Integrated Care, Workforce, Performance Measures, Value Based Payment, Social Determinants of Health) to ensure that population health is integrated in NY's health system transformation efforts. OPH staff have reviewed and provided input on key SIM and DSRIP documents, including the Advanced Primary Care standards and scorecard, DSRIP Project Plan Toolkit, Performing Provider System (PPS) lists of network partners, PPS applications and quarterly reports. OPH staff members have regular internal meetings to share report outs on workgroup activities, identify best practices and opportunities to incorporate population health into health system transformation, and listen to updates from invited speakers from the DSRIP, Public Health Improvement Program (PHIP) and SIM initiatives.

The Department has a range of population health activities supported by state and federal funding that are, or have the potential to be, leveraged to support the population health goals of SIM and DSRIP. These evidence-based initiatives include activities to increase the use of clinical preventive services, improve the linkages between the health system and community supports, and improve community-wide health. Below are examples of these activities:

Technical assistance on the Prevention Agenda

- Staff from OPH have partnered with the University at Albany School of Public Health and the New York Academy of Medicine to provide technical assistance to LHDs, hospitals, health care providers and community-based organizations who are working together to implement their community plans. The focus of the technical assistance (TA) has been on the chronic disease and mental health priority areas as those were the most commonly selected priorities by LHDs and hospitals. In-person trainings and over 30 webinars have been provided on topics such as nutrition standards, complete streets, tobacco control interventions, promoting breastfeeding, and evidence-based self-management programs. TA will continue in 2016 and include trainings on increasing colorectal cancer screening rates, improving hypertension management, and increasing medication adherence. Examples of TA provided to date: <http://www.albany.edu/sph/cphce/preventionagenda.shtml>

Traditional clinical approaches

Learning collaboratives

- OPH is partnering with Health Center Network of NY, 5 federally qualified health centers (FQHCs) and their associated LHDs through a learning collaborative model with the aim of improving hypertension control, diabetes control, identify patients with undiagnosed hypertension and prediabetes. Practices are testing and implementing evidence-based strategies proven to improve chronic illness care.
- OPH funds and works with eight regional asthma coalitions to recruit primary care practices to a learning collaborative based on the Chronic Care Model. Practices are testing and implementing evidence-based strategies proven to improve care for individuals diagnosed with asthma, such as establishing protocols that follow the current guidelines for care.
- Nine contractors work with OPH staff to recruit pediatric and OB/GYN practices to participate in a learning collaborative based on the Chronic Care Model. Practices are testing and implementing evidence-based strategies to deliver guideline-concordant care to increase breastfeeding and decrease obesity among infants and children aged 0-18 years.
- Staff from OPH has worked intensively with the 49 funded family planning programs (FPP) through a performance management initiative to increase the percent of female clients who leave a family planning visit with an effective or highly effective contraceptive method (Long Acting Reversible Contraception - LARC). Of the 49 FPPs, 15 agencies participated in a Learning Collaborative which was designed to build on the skills and knowledge participants gained during the performance management trainings and quality improvement work

Practice facilitation

- Staff from OPH has implemented an initiative to implement academic detailing and practice facilitation to increase breast, cervical and colorectal cancer screening within primary care practices, and to assess the outcomes and barriers to success. Three contractors provide academic detailing and practice facilitation services to primary care practices across Western and Central New York to assist practices in quality improvement activities, including practice enhancement and system-level change.
- OPH funds 57 LHDs outside of New York City to conduct Assessment, Feedback, Incentives and eXchange (AFIX) visits to healthcare providers who vaccinate children. AFIX is a quality improvement program to raise childhood and adolescent immunization coverage levels, reduce missed opportunities to vaccinate, and improve standards of practices at the provider level. One-quarter of NYS Vaccines For Children (VFC) program providers receive AFIX visits each year.

Health Systems for a Tobacco-Free NY

- OPH-funded contractors work to engage health care systems to improve the delivery of guideline-concordant care for tobacco dependence through systems change at the organizational level with the aim of expanding the reach of evidence-based smoking cessation interventions. Contractors work to establish tobacco dependence treatment systems consistent with the *Clinical Practice Guideline for Treating Tobacco Use and Dependence*. Other guideline-concordant systems improvements include sufficient training in evidence-based tobacco dependence treatment, dedicated staff to provide tobacco dependence treatment, cessation benefits that are widely available and promoted by health systems and their providers to increase utilization rates, removing barriers to using benefits and ensuring providers receive accurate feedback about their treatment practices.

Innovative patient-centered care and community linkages

Patient navigation

- OPH initiated a patient navigation demonstration project in two FQHCs; one focused in a 5-county rural section of Upstate NY (with a focus on breast and cervical cancer screening) and another in a region of NYC with a large population of Asian-Americans (with a focus on colorectal cancer screening). Patient navigators were trained to help address barriers in the target populations, discuss the importance of cancer screenings, and offer services such as identifying resources (e.g., transportation assistance) to help patients overcome barriers, communicating with provider offices to ensure that patients attend appointments, and helping patients receive diagnostic follow-up and treatment services, when necessary.

New York State Smokers' Quitline

- The New York State Smokers' Quitline offers free and confidential coaching, encouragement, resources, information about local cessation programs and ongoing support to all New Yorkers who want to quit tobacco use. The Quitline provides free starter kits of nicotine replacement therapy (NRT) to eligible New Yorkers. The Quitline also works with employers who want to sponsor cessation services to create healthier and more productive workplaces, and health care providers to ensure cessation support and services are offered and accessible to all tobacco-using patients.

In-home assessments

- Through the Healthy Neighborhoods Program (HNP), in-home assessments and interventions for asthma, tobacco cessation, indoor air quality, lead, fire safety, and other environmental health hazards are conducted, targeting housing in high-risk areas. The HNP uses a combination of door-to-door canvassing and referrals. An outreach worker provides education, referrals and resources. If someone with asthma is identified, a follow-up visit is made to provide asthma specific assessment and education.

Community health worker training modules

- OPH has contracted with an organization to develop online training for community health workers with an emphasis on skill building for improved management of hypertension and diabetes, including self-management and team-based care.
- OPH delivered core competency training to Community Health Workers (CHW) utilized by its 24 Maternal and Infant Community Health Collaboratives (MICHCs) as well as those 3 DSRIP Performing Provider Systems implementing CHW strategies along the MICHC model to increase support programs for maternal and child health (Project 3.f.i). The training is designed to provide CHWs with the information needed to find and case manage at-risk pregnant and parenting women and their families.

Evidence-based home visiting

- OPH implements the Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative which supports 7 Nurse-Family Partnership and 10 Healthy Families NY programs in high-risk communities throughout the state. Home visiting services include education, screening and referrals for substance abuse, maternal depression and domestic violence, as well as education and counseling on family planning, breastfeeding, immunizations, and the importance of the postpartum visit.

Maternal and Infant Community Health Collaboratives

- OPH supports 24 Maternal and Infant Community Health Collaboratives (MICHC) in 32 counties throughout the state to implement collaborative strategies that address maternal and infant health behaviors, supports and services systems across the reproductive life course (preconception, prenatal/postpartum, inter-conception). MICHCs work to find and engage high-need women and their families in health insurance, health care and other supportive services; ensure that the woman's medical, behavioral and psychosocial risks are assessed and addressed through timely and coordinated counseling, management, referral and follow-up; and promote opportunities and supports for women to engage in healthy behaviors.

Prediabetes toolkit

- Working with the SUNY Albany School of Public Health, OPH staff developed a prediabetes toolkit for healthcare providers containing diagnosis criteria, patient care guidelines, and information about diabetes prevention programs. LHDs, in support of Prevention Agenda priorities, have facilitated the dissemination of toolkits to healthcare practices and provide academic detailing on its use.

Community-wide Strategies

Creating Healthy Schools and Communities (CHSC)

- The OPH recently awarded 25 contractors funding to conduct a coordinated, multi-sector initiative designed to increase demand for and access to healthy, affordable foods and opportunities for daily physical activity in high-need school districts and their associated communities through sustainable policy, systems, and place-based changes that support the creation of healthier schools and communities. One Obesity Prevention Center for Excellence (OPCE) provides training, implementation support, and facilitates a learning collaborative with the 25 grantees. The OPCE will also conduct activities for local health departments in support of the Prevention Agenda.

Advancing Tobacco-Free Communities

- A statewide network of contractors, covering all counties in the state, use evidence-based strategies to create local environments that demand policy change and strengthen NY's tobacco-free norm. Contractor strategies include community education, community mobilization, advocacy with organizational decision makers, government policy maker education, and paid and earned media to promote these initiatives:
 - Point of Sale: To reduce the negative impact of retail tobacco product marketing and promotions on youth and adults, and continue to de-normalize tobacco use.
 - Tobacco-Free Outdoors: To increase the number of local laws, regulations and voluntary policies that prohibit tobacco use in outdoor areas.
 - Smoke-Free Multi-Unit Housing: To increase the percentage of individuals who are protected from secondhand smoke exposure by promoting smoke-free policies in multi-unit housing.
 - Smoke-Free Media: Working with local Reality Check youth, to promote policies that reduce tobacco use imagery in youth-rated movies and on the Internet, and educate communities and decision makers about the tobacco industry's use of social media.

Health communication campaigns

- OPH has several large paid media campaigns planned for 2016, including tobacco education, influenza and meningococcal vaccination, colorectal cancer screening, and sugar-sweetened

beverages. Campaigns are used to promote behavior changes and build public support for prevention initiatives and policies.

- OPH staff are working to increase appropriate use of antibiotics in outpatient settings using CDC's Get Smart: Know when antibiotics work campaign. Outreach has included both targeted, direct communication to healthcare providers as well as multiple collaborative efforts with LHDs and professional organizations to promote and increase the appropriate use of antibiotics among patients with upper respiratory infections.

Adolescent health

- OPH provides funding to 58 community-based organizations to reduce the risk of initial and repeat pregnancies, STDs and HIV among NYS adolescents in high-need areas statewide. Funding supports a multi-dimensional adolescent pregnancy prevention model that includes comprehensive, evidence-based, and medically accurate sexuality education; ensures access to comprehensive reproductive healthcare and family planning services for teens; and provides youth with educational, social, recreational, vocational and economic opportunities.
- OPH provides funding for 17 community-based organizations across the state to support adult mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in priority communities.

Enhancing school immunization requirements

- OPH amended NYS regulations in order to make school immunization requirements more consistent with Advisory Committee on Immunization Practices recommendations. Effective September 1, 2015, children who attend public, private or parochial school in NYS must receive all ACIP-recommended doses of all required vaccine series prior to school entry. Students who have not received all required doses must complete the series according to the ACIP schedule in order to continue to attend school, unless they have a valid medical or religious exemption to vaccination.

Appendix C: OMITTED

Appendix D: Master Operational Plan 2016 Matrix

Numerator Definition	Denominator Definition	Reporting frequency	Payment taxonomy	Denominator	Total target population	% of total target population	Notes
Total number of beneficiaries (individuals) cared for by providers contracted to start APC support by start of next year	Beneficiaries in Commercial (S) and (I) and Medicare Advantage	Quarterly and Annual	Categories 2 and 3	1,937,816	11,847,736	16%	Based on a number of assumptions including PCP coverage, ramp-up for 2016, expected contracting in participation of 2017, and APC panel coverage
Total number of beneficiaries (individuals) cared for by providers starting APC support in year	Beneficiaries in Commercial (S) and (I) and Medicare Advantage	Quarterly and Annual	Categories 2 and 3	164,920	11,847,736	1%	Based on a number of assumptions including PCP coverage, ramp-up for 2016, and APC panel coverage
Total number of providers completing Initial APC Milestone assessments	Total number of PCPs in the State	Quarterly and Annual	Categories 2 and 3	5,812	24,733	24%	Based on a number of assumptions including PCP coverage, ramp-up for 2016, expected contracting in participation of 2017
Total number of providers that have started to receive practice transformation technical assistance	Total number of PCPs in the State	Quarterly and Annual	Categories 2 and 3	495	24,733	2%	Based on a number of assumptions including PCP coverage, ramp-up for 2016
Total number of provider organizations completing Initial APC Milestone assessments	Total number of PCP organizations in the State	Quarterly and Annual	Categories 2 and 3	1,428	6077	24%	Based on a number of assumptions including PCP coverage, ramp-up for 2016, expected contracting in participation of 2017
Total number of provider organizations by practice TIN- that have started to receive practice transformation technical assistance	Total number of PCP organizations in the State	Quarterly and Annual	Categories 2 and 3	122	6077	2%	Based on a number of assumptions including PCP coverage, ramp-up for 2016
Total number of provider organizations by practice site- participating APC	Total number of PCP practice sites in the State	Quarterly and Annual	Categories 2 and 3	1,976	8409	24%	Based on a number of assumptions including PCP coverage, ramp-up for 2016, expected contracting in participation of 2017
Total number of provider organizations by practice site- participating APC	Total number of PCP practice sites in the State	Quarterly and Annual	Categories 2 and 3	188	8409	2%	Based on a number of assumptions including PCP coverage, ramp-up for 2016
The total number of beneficiaries (individuals) receiving care through providers contracted to participate in APC	Total State population	Annual	Categories 2 and 3	1,937,816	19,746,227	10%	Based on a number of assumptions including PCP coverage, ramp-up for 2016, and APC panel coverage

Appendix E: OMITTED

PA Focus Area	PA Population Health Indicator*	SIM APC Scorecard Indicator
	33 - Age-adjusted heart attack hospitalization rate per 10,000 34 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years 35 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	
Reduce Obesity	18 - Percentage of adults who are obese 18.1 - Percentage of adults aged 18 years and older with an annual household income less than \$25,000 who are obese 18.2 - Obesity among low income adults: Percentage of adults aged 18 years and older with disabilities who are obese 19 - Percentage of children and adolescents who are obese in NYC 20 - Percentage of children and adolescents who are obese in NYS excluding NYC 21 - Percentage of children (aged 3-17 years) with an outpatient visit that includes an assessment for weight status among Commercial Managed Care (CMC) members. 22 - Percentage of children (aged 3-17 years) with an outpatient visit that includes an assessment for weight status among Government Sponsored Managed Care (GSMC) members.	10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults
Priority: Prevent HIV/STDs, Vaccine Preventable Diseases, Healthcare Associated Infections		
Prevent HIV and STDs	39 - Newly diagnosed HIV case rate per 100,000 39.1 - Difference in rates (Black and White) of newly diagnosed HIV cases 39.2 - Difference in rates (Hispanic and White) of newly diagnosed HIV cases 40 - Percentage of HIV-infected persons with a known diagnosis who are in care 41 - Gonorrhea case rate per 100,000 women - Aged 15-44 years 42 - Gonorrhea case rate per 100,000 men - Aged 15-44 years 43 - Chlamydia case rate per 100,000 women - Aged 15-44 years 44 - Primary and secondary syphilis case rate per 100,000 men	2. Chlamydia Screening

PA Focus Area	PA Population Health Indicator*	SIM APC Scorecard Indicator
	45 - Primary and secondary syphilis case rate per 100,000 women	
Prevent Vaccine-Preventable Diseases	36 - Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months 37 - Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years 38 - Percentage of adults with flu immunization - Aged 65+ years	4. Childhood Immunization (status) 3. Influenza Immunization - all ages
Prevent Healthcare Associated Infections	46 - Hospital-onset CDIs new cases per 10,000 patient days 47 - Community-onset healthcare facility-associated CDIs new cases per 10,000 patient days	
Priority: Promote Healthy Women, Infants and Children		
Maternal and Infant Health	48 - Percentage of preterm births 48.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics 48.2 - Premature births: Ratio of Hispanics to White non-Hispanics 48.3 - Premature births: Ratio of Medicaid births to non-Medicaid births 49 - Percentage of infants exclusively breastfed in the hospital 49.1 - Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics 49.2 - Exclusively breastfed: Ratio of Hispanics to White non-Hispanics 49.3 - Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births 50 - Maternal mortality rate per 100,000 births 50.1 - Maternal mortality: Ratio of Black non-Hispanics to White non-Hispanics	
Child Health	51 - Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs 51.2 - Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs	

PA Focus Area	PA Population Health Indicator*	SIM APC Scorecard Indicator
	51.3 - Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs 52 - Percentage of children (aged under 19 years) with health insurance 53 - Percentage of third-grade children with evidence of untreated tooth decay obese in NYS excluding NYC 53.1 - Tooth decay: Ratio of low-income children to non-low income children obese in NYS excluding NYC	5. Fluoride Varnish Application
Reproductive, Preconception and Inter-conception Health	54 - Adolescent pregnancy rate per 1,000 females - Aged 15-17 years 54.1 - Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics 54.2 - Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics 55 - Percentage of unintended pregnancy among live births 55.1 - Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic 55.2 - Unintended pregnancy: Ratio of Hispanics to White non-Hispanics 55.3 - Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births 56 - Percentage of women (aged 18-64) with health insurance 57 - Percentage of live births that occur within 24 months of a previous pregnancy	
Priority: Promote a Healthy and Safe Environment		
Built Environment	5 - Rate of hospitalizations due to falls per 10,000 - Aged 65+ years 6 - Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years	
Injuries Violence and Occupational Health	7 - Assault-related hospitalization rate per 10,000 7.1 - Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics 7.2 - Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics 7.3 - Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes 8 - Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years	

PA Focus Area	PA Population Health Indicator*	SIM APC Scorecard Indicator
Priority: Promote Mental Health and Prevent Substance Abuse		
Mental Health and Substance Abuse Prevention	58 - Percentage of adolescents (youth in grades 9-12) reporting use of alcohol on at least one day for the past 30 days 59 - Percentage of adolescents (youth aged 12-17 years) reporting non-medical use of painkillers in the past year 60 - Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month 61 - Age-adjusted percentage of adult binge drinking during the past month 62 - Percentage of adolescents (youth grades 9-12) who felt sad or hopeless 63 - Percentage of adolescents (youth grades 9-12) who attempted suicide one or more times in the past year 64 - Age-adjusted suicide death rate per 100,000 65 - Age-adjusted percentage of cigarette smoking among adults who report poor mental health	12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 11. Depression screening and management

- Objectives are from the *Prevention Agenda 2013-2018* Dashboard
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard#

Appendix G: OMITTED

Appendix H: OMITTED

Appendix I: OMITTED

Appendix J: OMITTED

Appendix K: OMITTED