



New York State Health **Plan**

Innovation

December 2013



Executive Summary

New York’s State Health Innovation Plan (hereafter “the Plan”) is our roadmap to achieve the “Triple Aim” for all New Yorkers: improved health, better health care quality and consumer experience, and lower costs. We seek to achieve this through a multi-faceted approach that has at its heart an advanced primary care model that integrates care with all parts of the health care system, including behavioral health and community-based providers and aligns payment with this care model.

Over the past several years, New York has been a thriving incubator of health care innovation. New models for payment and care delivery, focused on delivering the Triple Aim, have been spearheaded by physicians, health systems, and other providers, with the active support of multiple consumer groups, our business community, as well as Medicare, Medicaid, the New York State Health Insurance Program (NY-SHIP), and more than a dozen private health insurers operating in the State. We have many individual success stories to celebrate. Our Plan builds on this significant experience, while sharpening our focus and aligning efforts going forward in order to bring innovations to scale.

Our goals for this Plan are ambitious. We aspire to:

- (1) achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement within five years;
- (2) achieve high standards for quality and consumer experience, including at least a 20 percent reduction in avoidable hospital admissions and readmissions within five years; and
- (3) generate \$5 to \$10 billion in cumulative savings by reducing unnecessary care, shifting care to appropriate settings, and curbing increases in unit prices for health care products and services that are not tied to quality, within five years.

New York State will achieve the Triple Aim within 5 years

	Goal
Improved health	<i>Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement.</i>
Better health care and consumer experience	<i>Achieve high standards for quality and patient experience, including at least a 20 percent reduction in avoidable hospital admissions and readmissions.</i>
Lower costs	<i>Generate \$5-to-10 billion in cumulative savings by reducing unnecessary care, shifting care to appropriate settings, and curbing increases in unit prices for health care products and services that are not tied to quality.</i>

The overarching premise for this Plan is a belief that “Advanced Primary Care” — (APC) defined as an augmented patient-centered medical home (PCMH) that provides patients with timely, well-organized and integrated care, and enhanced access to teams of providers — is the foundation for a high performing health system.

To that end, the State aims to achieve three core objectives within five years, namely:

- 80 percent of the population cared for under a value-based financial arrangement
- 80 percent of the population receiving care within an APC setting, with a systematic focus on prevention and coordinated behavioral healthcare
- full transparency over the cost and quality of care at every step of the health care value chain, enabling informed choices by consumers and purchasers

Medical homes have been shown to substantially improve access to needed care, receipt of routine preventive screenings, and management of chronic conditions, and to reduce or eliminate racial and ethnic disparities. Findings in NYS and nationally suggest that a health care system with a PCMH at its heart will achieve the Triple Aim. To that end, New York State is proposing a far reaching set of initiatives that are intended to support and create a more rational, patient-centered care system that is able to provide care that promotes health and well-being for all.

This document articulates and describes New York State’s broad strategy for achieving the Triple Aim, which includes five “pillars” (focusing on improving access, care management, increasing transparency, implementing value-based insurance design and community health) and three enablers (investments in the state’s health care workforce, in health information technologies and in systems to measure and report on quality, patient satisfaction and cost-effectiveness). These are the state’s overarching priorities, which have formed the basis for health reform efforts by the State over the past decade, and will continue to do so, over the next. The following are significant initiatives that the SHIP will build on, incorporate and evolve as part of an overarching vision for health in NYS:

1. New York’s Medicaid Redesign Team (MRT) and implementation of its far-reaching recommendations, including a series of delivery system/ payment system innovations such as Health Homes, Managed Long Term Care, a Fully-Integrated Duals Advantage plan;
2. the design and successful implementation of our new health insurance marketplace, The New York State of Health;
3. the commitment by the Office of Health Insurance Programs (OHIP) to improving the quality of primary care services available to Medicaid enrollees, by providing augmented payments to providers recognized by the National Commission on Quality Assurance (NCQA) as PCMHs.
4. the program elements and proposed investments contained in New York’s pending request to CMS for a Medicaid Waiver;
5. the State’s commitment to promote health at the community level through New York’s Prevention Agenda, community schools and the Community Opportunity and Reinvestment initiative;
6. the state’s commitment to implement electronic health records and put into place a statewide interoperable health information exchange and All-Payer Database (APD); and
7. the State’s commitment to promote and implement value based insurance.

The state’s proposed intervention – centered on statewide implementation of an Advanced Primary Care (APC) model, – seeks to align and leverage multiple ongoing initiatives (as noted above). All initiatives seek to create seamless integrated care systems that rely on evolving health information technologies and an emerging primary care workforce, and that aim to promote population health and improve well-being for all New Yorkers. This document describes how we plan to implement that model statewide, over the next five years, using multiple policy levers. A number of agencies within the state government together with the advice and input of external stakeholders will work to achieve this vision:

- The Department of Health (DOH) will provide leadership and discrete support for practice transformation, enhancements to the state’s health information technology, and a focused workforce development strategy; and it will provide ongoing oversight and management of the Medicaid program and the State Health Insurance marketplace (The New York State of Health);
- The Department of Financial Services (DFS) will encourage payers to support this new care model, and this Plan, through their regulatory oversight of commercial insurers in New York State;
- The Department of Civil Service (DCS) will support and participate in the implementation of this Plan through their oversight and administration of the State Health Insurance Program for the 1.2 million State and municipal employees; and
- The State Offices of Mental Health and Substance Abuse will participate in the design and implementation of the Plan, to assure that behavioral health and addiction services are well-integrated into the APC model.

The State is prepared to use a number of regulatory levers to achieve these transformation objectives, such as:

- Gaining consensus on standard reporting requirements for payers and providers
- Encouraging payer contributions to primary care to support practice transformation and care coordination to realize improved health and health system savings
- Providing payers with incentives to achieve penetration of value-based payment models and benefit design, as part of the rate-review approval process.

While the broad strategy is well understood and broadly supported by payers, providers, purchasers and consumer groups, the implementation of the Plan requires further definition. To that end, we have included in our implementation plan a detailed design and implementation planning phase, during which we will work closely with stakeholders to define and refine the changes that will be required; and at the same time reviewing existing policies, regulations, and laws to determine whether there are components that could enable and/or present a challenge to the Plan.

Within five years, we anticipate that our investments in this clinical innovation will translate to improved health, measurably lower prevalence of illness and injury, reduced health insurance premium rates, and a more sustainable growth rate in healthcare spending, approximately 2 percentage points below historical

trends¹. Our goal is to bring the growth of health care spending more closely in line with the growth of our economy—in other words, living within our means so that we can invest a greater share of our productivity gains in education, housing, and other priorities.

We believe that implementing the health system transformation outlined in this Plan is imperative not only to achieve the Triple Aim, but also to improve the competitiveness of businesses operating in New York State and ensure continued, strong economic growth in the years ahead.

OUR PAST EXPERIENCES AND CURRENT INITIATIVES POSITION US TO SUCCEED; OUR CHALLENGES MEAN THAT WE CAN WAIT NO LONGER

Our starting point as a State is defined by both strengths and challenges.

First, the State has strong momentum for shifting to a care delivery and payment model that prioritizes the continuous improvement of the patient experience, the achievement of relevant health care and population health outcomes, and improvements to the efficiency of the health care system.

- 25 percent of New York’s primary care providers have achieved recognition by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes;
- As of March 2013, 43 percent of Medicaid managed care members were assigned to a PCMH-recognized provider.
- 95 percent of the state’s commercial payers are testing value-based payment methods, including - but by no means limited to - involvement in a variety of medical home pilots and demonstrations across the state;
- New York’s Medicaid Redesign Team (MRT) agenda, has defined a path to integrated care for our Medicaid program, including the most vulnerable populations.²
- New York’s significant participation in programs sponsored by the CMS Center for Medicare and Medicaid Innovation (CMMI), involves more than 150 sites across the State.

¹ Health care spending per capita in New York State grew at a compound annual rate of 5.5% from 1999-2009, while gross state product per capita grew at a compound annual rate of 3.6%. Source for State health expenditures, Center for Medicare & Medicaid Services (CMS), www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence. Gross State Product Data: U.S. Bureau of Economic Analysis

² http://www.health.ny.gov/health_care/medicaid/redesign.

Second, the State has a strong foundation for innovation in our bold health information technology (HIT) agenda, which will integrate data across payers and provide the transparency necessary to improve patient care.

Third, the State has an ambitious and well-defined Prevention Agenda that sets the course for a new level of achievement in public health and prevention.³

Finally, the State and its health care stakeholders have a proud tradition of working together to expand access to coverage and services while striving to contain health care cost growth. While NY's spending per capita is 22 percent higher than the U.S. average New York ranks 29th in our health care share of gross State product and 32nd in our spending growth rate.⁴

These strengths will be pivotal in addressing our significant challenges:

- Our most critical challenge is cost—US health care costs are among the highest in the world, and NYS's health care spending per capita is 22 percent higher than the US average.
- Despite high expenditures, our quality of care by most measures is close to the national average, while the prevalence of preventable chronic conditions such as diabetes is rising quickly in New York State, as it is nationwide.
- We rank 50th among states for avoidable hospital use and 40th for ambulatory care-sensitive admissions.

Suboptimal quality means less healthy, less productive New Yorkers, and out-of-control costs hinder economic development for the State. These challenges underscore the urgency in mobilizing this Plan for change.

SHORTCOMINGS OF THE CURRENT SYSTEM

Our current health system fails to deliver the Triple Aim for several reasons:

- Health care providers and services, particularly primary care providers, are not evenly distributed throughout the State and distribution does not necessarily follow need or demand.
- Consumers and their families are largely left on their own to navigate a fragmented system of providers.
- Consumers and their families make health care decisions with little information, or sometimes are not actively involved in decisions made for them.

³ http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm.

⁴ Ibid.

- Providers are rewarded for delivering more care, supports or services, whether that care is needed or not.
- Providers who deliver high-quality care, supports or services see no financial benefit to doing so and may in fact be financially disadvantaged for doing so.
- Health care is delivered separate from rather than in concert with population health improvement and local health planning.

OUR PLAN'S FOUNDATION: FIVE STRATEGIC PILLARS AND THREE ENABLERS OF SYSTEM TRANSFORMATION

New York State's Plan to achieve the Triple Aim of improved health, better health care, and lower costs is grounded in our commitment to five strategic pillars

- 1. Improving access to care for all New Yorkers, without disparity**
- 2. Integrating care to meet consumer needs seamlessly**
- 3. Making health care cost and quality transparent to enhance consumer decision making**
- 4. Paying for value, not volume**
- 5. Promoting population health by strengthening capacity as well as promoting linkages between primary care, community resources, and policies for health improvement**

New York State Health Innovation Plan



Goal Delivering the Triple Aim – Better health, better care, lower costs

Pillars	1 Improve access to care for all New Yorkers, without disparity	2 Integrate care to address patient needs seamlessly	3 Make the cost and quality of care transparent to empower decision making	4 Pay for healthcare value, not volume	5 Promote population health						
	Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it	Information to enable consumers and providers to make better decisions at enrollment and at the point of care	Rewards for providers who achieve high standards for quality and consumer experience while controlling costs	Improved screening and prevention through closer linkages between primary care, public health, and community-based supports						
Enablers	<table border="1"> <tr> <td data-bbox="418 730 829 827"> Workforce strategy </td> <td data-bbox="829 730 1346 827"> A Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities </td> </tr> <tr> <td data-bbox="418 827 829 924"> Health information technology </td> <td data-bbox="829 827 1346 924"> B Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation </td> </tr> <tr> <td data-bbox="418 924 829 1018"> Performance measurement & evaluation </td> <td data-bbox="829 924 1346 1018"> C Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation </td> </tr> </table>					Workforce strategy	A Matching the capacity and skills of our healthcare 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
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The design of these pillars builds on the foundation set by the MRT and the Prevention Agenda, the blueprint for how the State will deliver the Triple Aim.

1. Improve access to care for all New Yorkers, without disparity

State goal for Pillar #1	<ul style="list-style-type: none"> ■ Reduce by 50 percent the proportion of adults without a usual source of care. ■ Reduce the size of our uninsured population by 1 million New Yorkers. ■ Substantially reduce waiting times for care.
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The first critical step is to ensure that New Yorkers have access, without disparity, to quality health care. The State has performed strongly in this area, with an uninsured population below the national average and relatively high per capita physician ratios. However, we aspire to do much better so that all New Yorkers have timely access to quality care, regardless of their circumstances – where they live, their eligibility for insurance, and/or their cultural or socioeconomic background. The SHIP will strive to assure appropriate access to quality care for

all New Yorkers including racial and ethnic minorities, people with limited English proficiency, immigrants, LGBT individuals and people with disabilities. Our strategy to achieve this has three components:

- Ensure that providers who serve vulnerable populations, including safety net providers who are essential to these populations, have the competencies and capacity to meet demand in a high-quality, timely way. Efforts like the Delivery System Reform Incentive Payment (DSRIP) Program that support safety net providers will be critical in this domain.
- For those eligible for coverage, increase the uptake and adoption of health insurance. A groundbreaking step toward achieving widespread coverage is the New York State of Health, our health exchange marketplace, which was established under the Affordable Care Act through an Executive Order issued by Governor Cuomo in April, 2012. It is here that New Yorkers, including the nearly 2.7 million New Yorkers under age 65 (12 percent of the State’s population) who do not have coverage, can shop, compare plans, and enroll in a plan that meets their needs.

We will continue to work to promote competitive pricing, high quality plans, and high levels of adoption via the exchange, and in parallel, ensure that other health insurance options such as Medicaid and CHIP are successfully reaching their target consumers.

- Grow primary care capacity to meet demand across the State, not just in major metropolitan areas, and to provide quality, culturally-appropriate care to everyone. To achieve this goal, we will continue to refine and expand programs aimed at balancing workforce supply and demand across the full spectrum of clinical capabilities.

2. Integrate care to meet consumer needs seamlessly

State goal for Pillar #2

Ensure that 80 percent of the population receives health care services through an integrated care-delivery model.

The Plan aims to cover as many New Yorkers as possible in an integrated care delivery model within five years. Specifically, we will work to ensure all New Yorkers have access to a new care model, the Advanced Primary Care (APC), which builds on the principles embodied by the NCQA-certified medical home.

As is shown below, the APC model is based on three progressively advanced levels of integrated care: Pre-APC, which includes most primary care practices in New York; Standard APC, a practice which meets and exceeds NCQA’s current standards for PCMH recognition; and Enhanced APC, practices in which behavioral health care services are integrated into the primary care setting, and the practice participates actively in initiatives focused on improving the health of the broader community.

The levels of APC capability reflect a practice’s capabilities and ability to better manage the health of its patient population. These models will need to be coupled with innovative, tiered payments that cover the incremental costs of registries, care coordination and care management, a variety of gain-sharing incentives for better managing care and costs, and up-front funding to help support technical assistance for practice transformation during the transitions between per-APC and Standard APC, and from Standard to Enhanced APC.

APC Stages of Transformation

Tier	Pre-APC	▶ Standard APC	▶ Premium APC
Description	<ul style="list-style-type: none"> Largely reactive approach to patient encounters of care 	<ul style="list-style-type: none"> Capabilities in place to more proactively manage a population of patients 	<ul style="list-style-type: none"> Processes in place to clinically integrate primary, behavioral, acute, post-acute care¹
Capabilities required to enter tier	<ul style="list-style-type: none"> Limited pre-requisites Willingness to exchange targeted clinical data 	<ul style="list-style-type: none"> Certified EHR Full medical home capabilities, aligned with NCQA Level 1-3, or equivalent 	<ul style="list-style-type: none"> Certified EHR, Meaningful Use Stage 1-3³, HIE interoperability Enhanced capabilities, aligned with expanded NCQA Level 3², or equivalent
Validation	None	<ul style="list-style-type: none"> Required to maintain care coordination fees >12 months To couple with practice transformation support 	
Care coordination skills	<ul style="list-style-type: none"> Limited or none 	<ul style="list-style-type: none"> Care planning for 5-15% highest-risk patients Track and follow up on ADT, other scalable data streams Facilitate referrals to high-value providers 	<ul style="list-style-type: none"> Plus, functional care agreements in medical neighborhood Plus, community-facing care coordination
Payment model mix	<ul style="list-style-type: none"> FFS + P4P Potential EHR support 	<ul style="list-style-type: none"> Shared savings or capitation Care coordination fees Transformation support 	<ul style="list-style-type: none"> Shared savings or capitation
Metrics and reporting	<ul style="list-style-type: none"> Standard statewide scorecard of core measures Consolidated reporting across payers, leveraging APD, portal 		

¹ Vision, LTC, home aids, rehabilitative & daycare are excluded from all advanced primary care models
² Establishes additional must-pass NCQA requirements that are not already mandatory in existing NCQA
³ Once available

The APC model is designed to leverage the strengths of New York State’s emerging NCQA-certified medical homes while laying out a graduated path for all practices to advance toward integrated care. For example, for providers involved in programs like the Medicaid PCMH Incentive Program, the APC model represents an evolution toward stronger integrated care and capabilities for care management.

The APC model will go beyond new structures and capabilities to specify and measure processes and outcomes associated with more integrated care, including prevention, effective management of chronic disease, integration with behavioral health, and coordination among the full range of providers working together to meet consumer needs. We believe this is essential in moving away from a reactive health care system that patients largely have to navigate on their own, to a truly proactive system, in which patients are helped to actively manage and improve their health.

Over the coming five years, we will work to actively promote participation in the APC by all major payers in the State - Medicaid, NY-SHIP, Medicare, and commercial payers, including self-insured arrangements with purchasers. The APC will provide care that is well integrated with services for special populations through unique care models such as health homes and the Fully Integrated Duals Advantage (FIDA) program.

Where there are adjacencies between the APC and other models serving special populations through these unique care models (Health Homes, the FIDA demonstration, and the behavioral health carve-in.⁵), the APC model is designed to reinforce the value of the primary care provider in supporting those populations.

At a programmatic level, the Plan will be harmonized with the pending MRT 1115 waiver⁶ and its related projects, such as the Delivery System Reform Incentive Payment (DSRIP) Program.

Processes to confirm eligibility, enroll providers into the program (for instance, on a payer by payer basis), measure progress, and align activities and outcomes with payment (see Pillar #4) will be developed in early 2014. In order to minimize the administrative burden, the eligibility process will be grounded in preexisting medical home recognition approaches such as NCQA or CPCi.

3. Make health care cost and quality transparent to empower consumer decision making

State goal for Pillar #3

- Achieve 80 percent PCP participation in the All-Payer Database and/or Health Information Exchange.
- Engage 20 percent of consumers in active use of their patient portal.

The Plan will generate an unprecedented level of health data transparency, which will empower consumers, providers, and payers to make increasingly informed decisions about the quality and costs of the care they seek and provide. Specifically, it is anticipated that within three-to-five years there will be statewide transparency of core quality, utilization and cost metrics at a facility and practice level, including a consumer-targeted website to provide this information in a user-friendly format to enable consumer action and shared decision-making.

⁵ For more detail on these programs, see Appendix, “Existing Programs and Waivers.”

⁶ http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf.

In addition, every New Yorker will have secure electronic access to his or her personal health records that include current health information from all providers he or she has accessed throughout the system. These records will be transferable to payers and providers and supported by interactive tools to help consumers optimize their healthcare decisions. These efforts will require essential technological infrastructure as well as strategies that make it both easy and rewarding for consumers to actively engage in health data and use it to make informed decisions about the care they access while ensuring the necessary privacy protections.

4. Pay for value, not volume

State goal for Pillar #4

- Ensure that 80 percent of covered lives are contracted under value-based payment models.

The Plan will promote incorporation of meaningful, value-based payment arrangements across the State’s payers and insurers, with the goal of rewarding providers who help patients stay healthy and achieve quality health care outcomes at an efficient cost.

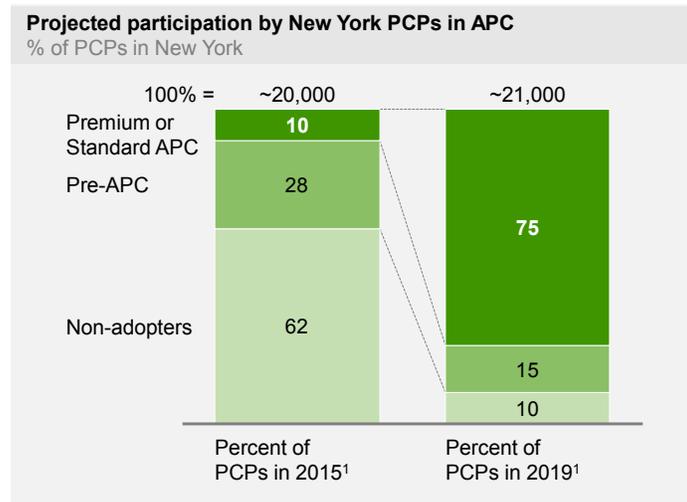
In order to promote innovation, the Plan’s goal is not to standardize specific payment arrangements or value-based models. Instead, a spectrum of ‘value-based payment models’ has been defined. Within this spectrum, payers and insurers can determine the detailed design and distribution of models they will develop in order to move towards the target of 80 percent of covered lives in value-based arrangements.

As a starting point for discussion, the spectrum of payment models for eligible APC practices could reflect a practice’s current status: pre-APC practices may be best suited to “pay-for-performance” arrangements, whereas more advanced, standard and enhanced APC practices may be better suited to participate in gain-sharing or risk-sharing arrangements.

The financial return to practices should increase as they advance their APC status – reflecting the additional value they create in helping their patients achieve strong health outcomes in a cost-effective way. Based on this framing of the payment spectrum and current estimates of NCQA recognition and EHR penetration, we project that nearly 40 percent of New York PCPs could be ready for some degree of APC participation in 2015 and that by 2019 the number will rise to 90 percent.

By 2019, 90% of New York PCPs will be on the glidepath of APC, with the vast majority at the Standard or Premium level

PRELIMINARY



¹ PCP includes internal practice, general practice, family medicine, OB/GYN, and pediatrics, ² Excludes dual eligibles
SOURCE: Kaiser Family Foundation; New York Department of Health; SK&A Data September 2013; CMS

The detailed design and distribution of payment models will be the responsibility of payers, working with providers. The Department of Financial Services (DFS) health insurance premium Rate-Review process will be refined to encourage a timely transition to at least 80 percent penetration of value-based payment models. The process will also recognize that achieving this goal may necessitate initial investments by insurers.

The State will also encourage broad use of value-based insurance design (VBID) by helping to create transparency about best practices in VBID and encouraging broad based adoption of such practices across payers (see Section 4, below). It is anticipated that Medicaid and NY-SHIP could take a leading role in this endeavor, implementing high-impact VBID into their plans, and that DFS could encourage increased use of VBID through its policy form approval process.

Finally, it should be noted that value-based payments in the APC model will complement value-based payment approaches focused on targeted populations. These include a number of Medicaid approaches such as the Behavioral Health carve-in to establish risk-bearing Special Needs Plans; Integrated Delivery Systems that specialize in managed care for patients with significant behavioral health needs; and the FIDA demonstration project, which enrolls Long Term Care (LTC)-intensive dually eligible members into fully integrated managed care products.

5. Promote Population Health

State goal for Pillar #5

- Connect 90 percent of PCPs to community-based organizations working to support population health through high-quality registries of community health-focused organizations.
- Promote regional health planning

We realize that many of the determinants of health and health care outcomes are influenced, if not determined, by factors outside the health care delivery system. The Plan uses the State Health Department’s Prevention Agenda 2013–2017 as a guide for building healthy communities and citizens and targets specific opportunities to enact and meet the goals and objectives of the Agenda. Specifically, the Plan will work to strengthen links between primary care, hospitals, long-term care providers, local health departments, and a variety of community stakeholders to ensure a truly integrated approach to identifying and addressing local health challenges. These linkages will focus on

- a. the prevention of chronic illnesses whose rise and prevalence are most threatening to the health of New York communities, including obesity, diabetes, heart disease, hypertension, smoking, and colorectal cancer;
- b. the promotion of healthy women, infants, and children;
- c. the provision of effective mental health and substance use prevention and treatment services; and
- d. the prevention of HIV, sexually transmitted diseases, and vaccine-preventable diseases.

The Prevention Agenda also prioritizes the promotion of health and safe environments and addresses local health disparities. Linkages will be created through regional resource centers involving county and city health departments and regional health planning organizations, such as Regional Health Improvement Collaboratives (RHICs), with opportunities for APC practices to take on a more proactive role in these community-based partnerships, e.g. by participating in regional health planning efforts.

APC practices are well positioned to help RHICs, whose responsibilities are to help community stakeholders identify opportunities to improve health care quality and value, facilitate planning and implement strategies that address those opportunities. In addition, community resource registries will be used to enable primary care practices to create effective linkages with community-based organizations and partnerships focused on aspects of prevention or health improvement (for instance, chronic disease self-management programs).

The types of organizations may vary according to regional needs; a simultaneous State and local priority should be to ensure there are sufficient and thriving community resources available. Measuring these linkages and the resulting population health outcomes will form a core part of the Plan’s evaluation focus at the system level, and will be reflected in the practice-level APC recognition processes and payment models.⁷

Transition toward Advanced Primary Care			
Tier	Pre-APC	Standard APC	Premium APC
Description	<ul style="list-style-type: none"> Largely reactive approach to patient encounters of care 	<ul style="list-style-type: none"> Capabilities in place to more proactively manage a population of patients 	<ul style="list-style-type: none"> Processes in place to clinically integrate primary, behavioral, acute, post-acute care¹
Capabilities	<ul style="list-style-type: none"> Selected medical home capabilities, aligned with specific NCCQA Level 1 must-pass sub elements, or equivalent 	<ul style="list-style-type: none"> Certified EHR Full medical home capabilities, aligned with NCCQA Level 1-3, or equivalent May require reinforced validation over time 	<ul style="list-style-type: none"> Certified EHR Meaningful Use Stage 1-3³ HIE interoperability Reinforced medical home capabilities, aligned with expanded NCCQA Level 3², or equivalent
Metrics and reporting		<ul style="list-style-type: none"> Standard statewide scorecard of core measures Consolidated reporting across payers, leveraging APD, portal 	
Payment model mix	<ul style="list-style-type: none"> FFS + P4P Potential EHR support 	<ul style="list-style-type: none"> FFS + gain sharing (+other) Care coordination fees Transformation support 	<ul style="list-style-type: none"> FFS + risk-sharing or global capitation Other
Potential upside to PCP income	▲	▲▲	▲▲▲

¹ Dental, vision, LTC, home aids, rehabilitative & daycare are excluded from all advanced primary care models
² Establishes additional must-pass NCCQA requirements that are not already mandatory in existing NCCQA
³ Once available

THREE ENABLERS ARE FOUNDATIONAL TO ALL STRATEGIES

A. Health care workforce strategy

A targeted health care workforce strategy, building on those of the MRT, will be deployed to assist in balancing the supply and demand of specific skills that will be required under the new APC model. The strategy has four areas of focus.

First, it is imperative to increase the recruitment and retention of a primary care workforce throughout the State. This includes not only primary care physicians but also health care workers who support the delivery of primary care, specialists who deliver primary care and ambulatory care providers.

⁷ http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm.

Second, it is essential to update standards and educational programs for all types of health care workers to reflect the needs of delivering the APC model, particularly training in care coordination, multidisciplinary teamwork, and necessary administrative and business skills. Effective care coordination will integrate care within and beyond the medical neighborhood⁸ to interface with relevant community organizations that provide supportive services such as food, housing and other social supports where they are available. It will also enable providers to address the needs of complex and vulnerable populations.

Third, it is critical to identify potential primary care-related workforce flexibility opportunities by putting in place the infrastructure to test and evaluate workforce models of care and their implications for professionals to work closer to the top of their licenses.

Finally, it is important to assure adequate education and training throughout the State and to develop more robust working data, analytics, and planning capacity. Although the focus of the Plan outlined in this document is on strengthening the primary care workforce, the State also intends to ensure appropriate capacity and competencies of the specialist care workforce, including mental health, long-term care, and home care providers.

B. Health information technology

Under the Plan, the State will build on and expand its current development and deployment of health information technology (HIT). This program will implement the aggregation of data through the All-Payer Database (APD) and the exchange of patient level clinical data via the Statewide Health Information Network for New York (SHIN-NY)—the State’s evolving, health information exchange architecture. This new architecture will provide the core analytic and reporting capabilities required to understand payer and provider-level outcomes, utilization, and costs, and will have an interoperable interface that offers decision support and transparency tools for payers, providers, and consumers.

In addition, these data platforms and NYS’s extensive public health database will be leveraged to provide communities (for example, the emerging Regional Health Improvement Collaboratives) with valuable population-level health data so that public health efforts are aligned with care delivery in the health system. Some of these tools will be State-developed, while others will be developed by local users and the private sector. Interoperability standards across providers will ensure that

⁸ The medical neighborhood refers to the collection of teams, practices, and community resources that provide health services, or services in support of health, to patients. From a primary care point-of-view, this includes other specialist care and hospital care that a practice’s patients utilize, as well as community and social service organizations and public agencies.

HIT investments by stakeholders will enhance the ability to produce and use “big data” to improve care, from the patient to the system level.

C. Performance Improvement: Quality Measurement and Evaluation

The State, through collaboration with stakeholders, will develop a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivery within the State Health Innovation Plan. A core set of industry-standard metrics will serve as a common basis for measuring progress and impact of the Plan as well as that of the new APC model. Existing metrics from the MRT, health plans, and hospitals will provide the basis for this approach and will be augmented and triangulated with selected metrics from the Prevention Agenda, the Collaborative Care model, multipayer Advanced Primary Care demonstrations such as the Comprehensive Primary Care initiative (CPCi), and the Multipayer Advanced Primary Care Practice Demonstration (MAPCP) and other industry standards.

This Plan contains a rigorous first draft of a proposed ‘standard scorecard.’ The final set of measures will be determined with input from key stakeholders over the coming months and then published as the statewide standard. To encourage statewide adoption, these will be the measures supported by the State-led HIT infrastructure and standardized reporting, and will be used as the basis for all Medicaid and NY-SHIP contracts and for increasing use in commercial contracts. Importantly, these measures will evaluate important dimensions of quality including outcome-linked processes, health outcomes, utilization, patient experience and efficiency.

In addition to measuring performance improvement at the provider, practice and payer level, the State will comprehensively evaluate system transformation in order to ensure a strong trajectory toward our system level goals: achieving top quartile performance among states in prevention and public health; greater than 20 percent improvement in avoidable admissions and readmissions; and 2 percent annual cost reduction against trend resulting in \$5-10 billion in cumulative savings over 10 years.

THROUGH A FIVE-YEAR TRANSFORMATION, WE WILL USHER IN A NEW ERA OF HEALTH CARE VALUE, AND A HEALTHIER NEW YORK

The transformation roadmap reflects our bold commitment to moving the needle on the Triple Aim in the next five years. It also reflects our commitment to making this process a truly collaborative journey, thus allowing time for sufficient and

meaningful engagement with all the partners who work together to deliver health care in New York.

The transformation journey will have four key phases:

- **Finalize the detailed Plan design (January–September 2014).** During this phase, we will establish the State-level delivery and governance mechanisms to drive the Plan’s finalization and implementation and set up the key stakeholder working groups required to help us navigate the journey ahead. A key part of this phase will be working through the detailed design of the operating model – including how practice transformation will be supported, how care coordination will be enabled, and precisely how the Rate Review process will operate. In addition, work will be undertaken to ensure that the necessary funding is in place to support Plan delivery and, in particular, delivery of the HIT enablers such as the APD and EHR adoption. We will begin to define common performance metrics, align on a common dashboard to measure the Plan’s progress, and develop a statewide APC performance tool for providers and payers.
- **Prepare for implementation (October 2014–April 2015).** During this phase, we will lay the groundwork for the new operating model, including building regional support capabilities where required, publicizing APC eligibility standards, and building provider access points and APD-based analytic capabilities. We will advance any regulation or legislation required to support the capture and flow of data required for maximum effectiveness of the APD and the SHIN-NY. The rollout of the HIT program will progress at a steady pace.
- **“Go live.” Supporting transformation (April 2015–April 2016).** In this phase APC recognition will begin. DFS will start conducting rate reviews using a newly enhanced process that recognizes payer innovations and investments in APC models. Health data transparency and reporting will begin to reach scale, and the State will work to support regional governance entities as they operationalize practice transformation and care coordination efforts and supports. In addition, the State will encourage the participation of purchasers in self-insured arrangements and support the implementation of Medicaid and NY SHIP approaches to APC.
- **Continuous improvement and refinement (April 2016 onward).** Refinement of the care and payment model(s) will continue to evolve based on experience. The connection of APCs to population health in the community will continue, and ongoing refinement of common measures to ensure relevance to all stakeholders will take place. The State will work with stakeholders to ensure that information and reporting are optimized and to identify and resolve challenges as they arise. Evaluations and feedback from

all stakeholders will guide appropriate evolution of standards and best practices

THE STATE WILL LEAD EXECUTION OF THE PLAN IN CLOSE PARTNERSHIP WITH STAKEHOLDERS

In order to achieve this ambitious end-state, the leadership role of the State will be important. Our leadership team reflects cross-agency collaboration across our departments of Health, Financial Services, and Civil Service (in its role as the health care purchasing arm of the State’s Council on Employee Health Insurance), as well as other health-related State agencies. That momentum already exists among payers and providers. To move in the direction outlined by the State Health Innovation Plan, New York will focus on removing barriers, enabling standardization where required, and encouraging rapid adoption of the targeted care delivery and payment models. Specifically, the State will support execution of the Plan in three ways:

- **Convening and facilitating alignment:** The State—through a cross-agency collaboration of DOH, DFS, DCS, and DOB, and including providers and payers—will facilitate alignment in four key ways.
 - *First*, it will work within the NCQA patient-centered medical home recognition process to reflect the three proposed APC levels, and will consider adapting the process if practicable and if needed, thereby building on the existing NCQA framework to minimize the administrative burden on practices and payers. Transitional recognition for both current NCQA and other industry standards (for example, CPCi) will be maintained for a defined period. The State will be open to other options for recognition of APC eligibility as needed.
 - *Second*, it will facilitate the collaborative creation of, and then actively promote the adoption of, industry-standard metrics by publishing a core list of APC metrics, using these metrics in its Medicaid and NY-SHIP contracts related to APC, and, as mentioned above, supporting APC metrics via state-enabled HIT. The core list of metrics will represent a beginning set of metrics, with room for regionally-tailored metrics to supplement the set.
 - *Third*, the State will act as a facilitator by encouraging the formation of regional support models to assist practice transformation and convene shared resources for care coordination. In doing this, the State will build on existing collaborative arrangements that have already gained significant traction (for example, in the Finger Lakes and Adirondacks) while also seeking to leverage other regional structures (including county health

departments and potentially, the 11 newly proposed Regional Health Improvement Collaboratives).

- *Finally*, the State will facilitate a broader stakeholder engagement process to ensure that multiple perspectives are reflected in the final design and implementation.
- **Delivering:** The State will play the lead role in delivering three key enablers of the Plan pillars.
 - *First*, it will continue building the backbone of the HIT system to enable required flows of data between payers, providers, purchasers and consumers (through large-scale efforts such as the APD and the SHIN-NY).
 - *Second*, it will define the beginning, core set of metrics for quality, utilization, and cost performance.
 - *Third*, it will support the analytic engine to collect and report on these metrics, delivering core information required to support the APC model and associated payment models to all system participants, including providers and payers.
- **Incentivizing:** The State will explore using the Rate Review process as a core mechanism to encourage payer innovations and investments in the implementation of APC models developed in collaboration with participating providers. The process may also be used to align payer progress and policies with the Plan, including moving toward the adoption of APC models and associated value-based payment.
- The State intends to work closely with payers and providers in finalizing the design of this process, recognizing that insurers may need to make initial investments in prepared provider practices in order to innovate. The intention is to provide payers as much flexibility as possible to innovate and autonomously manage their portfolio while ensuring that the health system as a whole moves away from fee-for-service payment and toward a value-based payment model over time. To achieve this, it is anticipated that, as part of the Rate Review process, payers will have an opportunity to report on how their provider portfolio is distributed against value-based payment models, including the APC recognition levels and to describe the penetration over time of value-based payment models and VBID.

OUR GOVERNANCE MODEL WILL ENSURE CROSS-AGENCY COORDINATION AND PUBLIC-PRIVATE COLLABORATION

Our State Health Innovation Plan is ambitious. Effective delivery over the next five years, and in particular during the critical start-up period over the next two

years, will require extensive collaboration and coordination both among the agencies of New York State and across the regional and statewide stakeholders that constitute New York's health care landscape. As a State we have demonstrated large-scale transformations multiple times in the past: we know how challenging it is, but we also know what it takes. Importantly, we know that a key enabler of success is a clearly-defined governance model, coupled with a high-powered, high capability program management office that ensures cross-agency coordination, private-sector collaboration, and accountability to the Plan.

Our approach to governance reflects three key beliefs regarding what it will take for New York to succeed:

- **Consistent coordination among State agencies with a stake in Health.** The health of every New Yorker and the long-term solvency of our State's economy are at stake; hence, the Department of Health (DOH), Department of Civil Service (DCS), Department of Financial Services (DFS), and the Division of Budget (DOB) must lead the way together, each marshaling its expertise and resources to meet their shared mandate, and coordinating with one another to generate the most effective implementation the State can achieve. These four agencies will jointly own the delivery of Plan outcomes, with the Commissioner of the Department of Health taking the lead.
 - The leadership team will include other key health-related agencies, including the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), as well as agencies whose programs and services impact health, such as Housing and Children and Family Services. Governor-led initiatives such as Community Schools will also be included. The 38 individual initiatives that jointly comprise the Plan are allocated to agency and department level ownership. Finally a high visibility, high capability Program Delivery Office will be established to coordinate across agencies and ensure delivery against our ambitious goals.
- **Strong public-private collaboration.** Our care delivery system comprises a complex array of stakeholders; all need to be a part of the solution. There will be a stakeholder steering committee charged with aligning on overarching design and implementation issues.
 - We will establish a health delivery system workgroup inclusive of both providers and payers with the mandate and capacity to agree on core principles of payment models that support and encourage the delivery transformation this plan seeks to achieve. This group will also be charged with developing recommendations to create a standardized set of performance metrics and will be asked to leverage shared HIT platforms like the APD.
 - Additional Groups will be convened to ensure that this effort is truly collaborative and will include representatives familiar with consumers,

community and regional efforts, employers, public health, workforce and other health care stakeholders. Our Program Delivery Office will ensure tight integration between Steering Groups and internal, cross-agency working teams.

- **Regional oversight of implementation.** The richness of capabilities, depth of contextual knowledge, and deep commitment of our regional partners mean that progress and success should be driven locally. We wish to enable regional entities to lead Plan implementation in ways that make most sense.
 - Regional entities will be best equipped to set local priorities, convene local stakeholders, and support mechanisms of regional implementation, such as regional contracting to provide practice transformation.
 - In the coming months, we will work together with our Steering Groups to define how to optimally integrate entities like the proposed Regional Health Improvement Collaboratives and local Prevention Agenda partnerships, local county health departments, and a strong roster of preexisting convening organizations across New York communities. Once this has been determined, we will work quickly to support and enable regional entities to take stock of the resource and capability needs that must be addressed to jointly deliver on the full aspirations of our Plan.

* * *

Achieving the Triple Aim is not a choice, it is an imperative. Our State Health Innovation Plan is not just an opportunity; it is an obligation that we, collectively across our health care system, have to all New Yorkers.

New Yorkers across the State, of all economic and cultural backgrounds and across the spectrum of health needs, deserve a health care system that delivers high quality, cost-efficient care with only the best outcomes. They deserve health care, supports and services that comprehensively attend to whole person-centered health, from the primary care setting throughout the medical neighborhood and into the community, and that is tightly harmonized with community efforts to support healthy populations.

It is imperative not only to support quality, healthy lives, but also to ensure that New York State continues to grow as a vibrant, strong economy.