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# GLOSSARY OF NEW YORK STATE HEALTH REFORM

## ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

An Accountable Care Organization (ACO), as defined by New York State, is an organization comprised of independent but clinically-integrated health care providers that work together to manage and coordinate health care for a defined population. An ACO has a shared governance structure with the ability to negotiate, receive, and distribute payment, and is accountable for the quality, cost, and delivery of health care to the ACO's patients.

The State has issued regulations establishing its standards for certification of ACOs. Under these regulations, ACOs must establish a representative governing body and management structure to provide oversight and strategic direction, and are required to implement quality management programs and report to the State on their performance on quality metrics. A state ACO may apply for state action immunity, which provides certain protections from being prosecuted under federal and state antitrust laws. Existing Medicare ACOs, which participate in the Medicare Shared Savings Program (MSSP) and are approved by the Centers for Medicare and Medicaid Services (CMS), do not have to submit an application and may receive state ACO certification through an expedited process. However, these certificates apply only to their actions related to Medicare beneficiaries.

Independent Practice Associations (IPAs) and Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPSs) are among those organizations eligible to seek ACO certification. Applications are reviewed on a rolling basis. To date, ACO certificates have been issued only to eight existing Medicare-only ACOs.

## BALANCING INCENTIVE PROGRAM (BIP)

The Balancing Incentive Program (BIP) is a federal grant to improve access to long-term supports and services (LTSS) provided outside of nursing homes and other institutions. Under the BIP, the State receives a 2 percent increase in the federal matching funds rate for these kinds of services. This will total about $600 million. In return, the State will: (1) enhance "no wrong door/single entry point" efforts to deliver consistent information about LTSS options and offer enrollment assistance; (2) implement a standard set of assessments; and (3) establish conflict-free case management, as determined by federal standards.

The BIP began in April 2013 and was originally scheduled to run through September 2015. However, CMS and the State have agreed to allow an extension of existing BIP activities with no additional funding through September 2017, to be approved by the State on a case-by-case basis.

## BEHAVIORAL HEALTH (BH) CARVE-IN

NYS has started the process of carving in behavioral health services for all enrollees in mainstream Medicaid managed care plans. This will take place in two ways over the next few years. First, existing BH services are being added to the mainstream package and carve-out exclusions for individuals on Supplemental Security Income are being eliminated. All mainstream Medicaid managed care plans had to demonstrate that they are qualified to manage BH services themselves or partner with an experienced organization, such as a Behavioral Health Organization (BHO). Second, plans may create new, specialized managed care plans called Health and Recovery Plans (HARPs) for adults with significant BH needs. Plans electing to offer HARP plans are required to demonstrate a capacity to manage such plans. In addition to the basic BH benefit package, HARP plans include Home and Community Based Services (HCBS) as part of the benefit package for individuals who are assessed to need such services.

A Request for Qualifications (RFQ) was released on March 21, 2014 to qualify mainstream plans in NYS to manage the behavioral health benefit. The carve-in of BH services for adults went into effect on October 1, 2015 in NYC and is planned for July 1, 2016 for the rest of the State. The BH carve-in for children is expected

to begin January 1, 2017 in NYC and Long Island and July 2017 for the rest of the State.

## Health and Recovery Plans (HARPs)

A Health and Recovery Plan (HARP) is a specialized managed care plan for people with significant behavioral health (BH) challenges or substance use disorders (SUD). HARPs will provide a range of new home and community-based services (HCBS) to their members, including psychological rehabilitation, community psychiatric support and treatment, respite, and peer supports. Non-dual eligible individuals over 21 may qualify for HARPs if they have a serious mental illness (SMI) or SUD diagnosis. To determine eligibility, the State and HARPs will perform quarterly data reviews of historical service usage to identify members who meet one of thirteen HARP risk factors. Additionally, individuals may be identified by the service system or providers as having serious functional deficits, either through individual case review (using the HARP risk factors) or through a HARP eligibility screen.

Individuals who are deemed to be HARP-eligible will be offered enrollment in a Health Home where they will receive a functional assessment to determine which services should be provided. Health Homes will provide conflict-free care management to HARP enrollees. The first phase of enrollment for NYC HARPs is taking place between October 2015 and January 2016. Enrollment for the rest of the State will begin in April 2016.

## Home and Community Based Services (HCBS) (formerly 1915(i)-like Services)

The HCBS waiver program provides opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community and decrease the need for inpatient care. HARP-eligible enrollees will have the ability to access an enhanced benefit that includes an array of HCBS services. These services include:

- Psychosocial Rehabilitation (PSR);
- Community Psychiatric Support and Treatment (CPST);
- Habilitation/Residential Support Services;
- Family Support and Training;
- Short-term Crisis Respite;
- Education Support Services;
- Empowerment Services-Peer Supports;
- Non-Medical Transportation;
- Pre-vocational Services;
- Transitional Employment;
- Intensive Supported Employment; and
- Ongoing Supported Employment.

HCBS services are scheduled to become available for HARP-eligible individuals in NYC on January 1, 2016. Agencies that provide HCBS services must be designated for each service that they offer and attest to meeting the staffing and service delivery criteria as outlined in the HCBS provider manual. In the rest of the

State, HCBS services for HARP-eligible individuals are expected to become available on October 1, 2016.

### HCBS for Children

HCBS services for children are expected to become available in January 2017 in NYC and on Long Island and in July 2017 for the rest of the State. The designation process for children's HCBS services has not been released yet. The proposed services for children include:

- Family Care Supports & Services;
- Skill Building;
- Crisis Respite;
- Planned Respite;
- Pre-Vocational Services;
- Supported Employment;
- Community Advocacy & Support;
- Non-Medical Transportation;
- Day Habilitation;
- Adaptive & Assistive Equipment;
- Accessibility Modifications; and
- Palliative Care (family education, pain/symptom management, bereavement services, massage therapy, expressive therapy).

The Child and Adolescent Needs and Strengths Assessment for New York (CANS-NY) will be used to determine HCBS eligibility for children.

## COMMUNITY FIRST CHOICE OPTION (1915(K))

The Community First Choice Option (CFCO) program allows states to provide home and community-based services to individuals who are Medicaid-eligible; have an income less than 150 percent of the Federal Poverty Level; and require an institutional level of care, such as care provided in a hospital, nursing facility, institution for mental diseases (IMD), or intermediate care facility (ICF).

The CFCO program requires participating states to offer services by direct-care workers to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks. Attendant services include hands-on assistance, safety monitoring, and cueing. The state must also create a training program to assist individuals in selecting, managing, and dismissing personal care attendants.

The CFCO SPA in NYS was approved by CMS and became effective as of July 1, 2015.

## CONFLICT-FREE CASE MANAGEMENT

CMS is implementing mandatory conflict-free case management policies in states that are receiving Medicaid funds from the Balancing Incentive Program (BIP), Community First Choice 1915(k) state plan

option, or the HCBS state plan option. Conflict-free case management requires the separation of clinical eligibility determinations and care planning assessments from the direct provision of services. Providers are expected to implement conflict of interest standards and establish protocols for removing potential conflicts of interest.

## DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

The Delivery System Reform Incentive Payment (DSRIP) program is the primary funding mechanism of New York's $8 billion dollar federal waiver to redesign the Medicaid program and achieve the Triple Aim of improved care, enhanced quality, and reduced costs. Over $6.4 billion will be allocated to the DSRIP program, which has the overall goal of reducing avoidable hospitalizations in the State by 25 percent within its five-year lifespan.

DSRIP Year 2 will begin on April 1, 2016. The program is scheduled to end on March 31, 2020.

### Performing Provider System (PPS)

To participate in DSRIP, providers formed coalitions referred to as Performing Provider Systems (PPSs). Most PPSs are led by large safety net hospitals and/or public hospital systems and incorporate large networks of health care providers spanning the spectrum of services. Medicaid beneficiaries and, in limited cases, the uninsured are attributed to a specific PPS, generally based on where they receive the plurality of their care. Currently, there are 25 PPSs:

| | | | | |
|---|---|---|---|---|
| Adirondack Health Institute | CNY PPS | Millennium Collaborative Care | NYC Health and Hospitals | Stony Brook University Hospital |
| Advocate Community Partners | Ellis Hospital | Mohawk Valley PPS (Bassett) | Refuah Health Center | New York Presbyterian Hospital |
| Albany Medical Center Hospital | Finger Lakes PPS | Montefiore Medical Center | RUMC & SIUH | NY Hospital Med Center of Queens |
| Bronx-Lebanon Hospital Center | Lutheran Medical Center | Mount Sinai Hospitals Group | Samaritan Medical Center | United Health Services Hospitals |
| Catholic Medical Partners | Maimonides Medical Center | Nassau University Medical Center | St. Barnabas Hospital | Westchester Medical Center |

Each PPS has designed a Project Plan that incorporates between five and ten DSRIP projects that aim to create system transformation, improve clinical services, and address population-wide health issues. Certain PPSs have the opportunity to undertake a special 11th project to engage people who are not well-connected to the health care system into community-based care.

The State has set a "maximum application value" for each PPS. The maximum application value is the total potential dollars a PPS can earn and was calculated based on the following factors:

- **Project index score:** The relative value of the chosen projects;
- **Population:** The size of the attributed population;
- **Plan application score:** The strength of the application;

- **Per member per month rate:** A rate based solely on the number of projects chosen; and
- **Project period:** 60 months for all applications.

In order to receive DSRIP payments, PPSs must meet project-specific performance targets set by the State and PPSs that surpass their performance targets may receive bonus payments. Beginning in DSRIP Year 3, payments will also be tied to the aggregate performance of all PPSs throughout the State. The first round of DSRIP payments were allocated to PPSs in May 2015 and the second round are expected to be allocated by the end of January 2016.

## Project Approval and Oversight Panel (PAOP)

The Project Approval and Oversight Panel (PAOP) is a federally-mandated advisory panel whose members have been tasked with reviewing PPS Project Plans. After PPS Project Plans were objectively scored by an independent assessor, the PAOP reviewed each Plan based on subjective measures such as project justification, cultural competence, and financial sustainability. All PAOP recommendations were reviewed by the NYS Commissioner of Health and CMS before final approval.

The PAOP will continue to monitor PPS progress throughout the five-year program and will make recommendations on changes to PPS networks and projects in DSRIP Year 3. The PAOP will also review the allocation of funds for the Capital Restructuring Financing Program (CRFP).

## Capital Restructuring Financing Program (CRFP)

The Capital Restructuring Financing Program (CRFP) is a NYS-funded program that will make available up to $1.2 billion in grants to support the capital needs of DSRIP projects. Capital grant projects include, but are not limited to: closures; mergers; restructuring; improvements to infrastructure; development of primary care service capacity; development of telehealth infrastructure; and the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services and other transformational projects.

CRFP applications were originally due in February 2015, but applicants resubmitted their applications in September 2015 after the enacted NYS 2015-2016 budget required that funds be awarded regionally in proportion to the applications received. As such, funds will be split into two pools: one for the five boroughs of New York City and one for the rest of the State, and projects will compete within these pools for funding. The State has not released a timeline for the allocation of CRFP funds.

## Equity Infrastructure Program (EIP)

The Equity Infrastructure Program (EIP) is a supplemental DSRIP program that will provide an additional $938 million in payments to certain PPSs, most of which were not eligible to undertake the 11th project. To be eligible for EIP payments, PPSs must demonstrate participation in four of nine DSRIP-related activities: IT Target Operating Model (TOM) initiatives; Medicaid Accelerated eXchange (MAX) Series projects; Health Home enrollment expansion; EHR implementation investment; capital spending on primary/behavioral health integration; tobacco cessation programs; efforts to end HIV/AIDS; fraud deterrence and surveillance; or Statewide Health Information Network of New York (SHIN-NY) infrastructure spending.

Participating PPSs will be required to contract and work closely with an assigned Medicaid managed care organization (MCO) to ensure that EIP activities are aligned with the State's transition to value-based payments (VBPs). EIP payments will be administered through the assigned MCO and will be contingent on the PPS's ability to meet program requirements.

It is estimated that $738 million will be allocated to safety net PPSs and $200 million will go to public PPSs. The State has not announced a timeline for the allocation of EIP payments.

## Equity Performance Program (EPP)

The Equity Performance Program (EPP) is a supplemental DSRIP program that will provide an additional $642 million in payments to certain PPSs to improve their performance on a subset of critical DSRIP metrics. The same PPSs eligible for the EIP are also eligible for the EPP. The State has proposed to base EPP payments on 18 DSRIP measures that are applicable to a significant portion of the Medicaid population, are related to important subpopulations, and/or support VBP activities. To receive EPP funding, PPSs must meet performance requirements on six of the eighteen measures.

Qualifying PPSs will be required to contract and work closely with an assigned MCO to ensure that EPP activities are aligned with the State's transition to VBPs. EPP payments will be disbursed monthly through the assigned MCO and will be contingent on the PPS's ability to meet specific performance metrics.

It is estimated that $492 million will be allocated to safety net PPSs and $150 million will be allocated to public PPSs. The State has not announced a timeline for the allocation of EPP payments.

## Value-Based Payment (VBP) Roadmap

New York's VBP Roadmap is a five-year plan that describes how Medicaid MCOs and providers will move away from fee-for-service (FFS) payments and towards the statewide use of VBP methodologies. The Roadmap was approved by CMS in July 2015 and is intended to build upon improvements to the health care system made through DSRIP. The State's goal is to move 80-90% of managed care payments to value-based methodologies by DSRIP Year 5.

The State envisions that MCOs and provider networks will negotiate with each other to develop VBP arrangements. While PPSs will play a major role in this process, all groups of providers including, but not limited to, IPAs and ACOs are eligible to participate in VBP contracting. The State has proposed the following VBP models: Total Care for the Total Population; Integrated Primary Care; Care Bundles; and Special Needs Subpopulations. MCOs and providers will be able to combine these options or receive approval to implement "off-menu" payment models.

Under each payment model, MCOs and providers may choose to take on the following levels of risk: FFS with potential outcome-based quality incentives and no risk-sharing (Level 0); FFS with the potential for upside-only shared savings (Level 1); FFS with the potential for upside and downside risk sharing (Level 2); and prospective capitation per member per month (PMPM) or care bundles (Level 3).

In May 2016, NYS will submit the first of numerous annual reports detailing the State's VBP progress.

## VBP Workgroup

The VBP Workgroup is a group of stakeholders convened by the State to develop and implement the VBP Roadmap. Members include representatives from State agencies, insurers, providers, advocacy groups, and labor unions. The VBP Workgroup has established subcommittees and clinical advisory groups to administer the State's transition to VBP. Five subcommittees have been created to generate guidance and standards to:

1. Establish technical design for VBP models;

2. Establish technical design for outcome measures and benchmarks;

3. Address regulatory and contractual barriers to VBP implementation;

4. Improve advocacy and engagement with the Medicaid population; and

5. Include social determinants of health and community-based organizations in payment methodologies.

The VBP Workgroup and subcommittees will continue to meet regularly over the next four years.

## Clinical Advisory Groups (CAGs)

Clinical Advisory Groups (CAGs) were established by the VBP Workgroup to define parameters and quality measures for specific VBP models. Each CAG is comprised of clinical experts who are tasked with designing a targeted approach for a specific population or condition. CAGs have been established for the following populations and conditions:

- Maternity;
- Chronic Heart/Diabetes;
- Pulmonary;
- Substance Use Disorder;
- Behavioral Health;
- HIV/AIDS;
- Managed Long Term Care; and
- Developmentally Disabled.

CAGs will meet regularly over the next four years and more CAGs may be established over time.

## VBP Quality Improvement Program (QIP)

The VBP Quality Improvement Program (QIP) will provide an estimated $320 million to support financially-strained hospitals through the transition to value-based payments. The NYC Health and Hospitals Corporation (HHC) is expected to receive $120 million in funding, while non-HHC facilities are expected to receive $200 million, pending a federal match.

Over the five-year program, qualifying hospitals will work closely with an assigned MCO and their PPS lead to develop a QIP Plan that will allow the hospital to enter into Level 1 of VBP contracting by April 2016. QIP funding will be allocated from the State to the MCO and then funneled through the PPS to the hospital. In addition to flow of funds, the MCO and PPS will ensure that the hospital's QIP Plan is aligned with DSRIP goals and the VBP Roadmap. Participating hospitals are required to submit a final QIP Plan to their assigned MCO and PPS by February 12, 2016. MCOs and PPSs are scheduled to approve hospital plans by February 19, 2016. The following MCO-PPS-Hospital arrangements have been designated under this program, but other hospitals may apply in future years:

| MCO | PPS | Facility | Estimated Need |
|---|---|---|---|
| HealthFirst | Advocate Community Providers | Brookdale Hospital | $51,993,881 |
| | New York City Health and Hospitals Corporation | HHC (Secondary Lead) | $53,779,932 |
| MetroPlus | New York City Health and Hospital Corporation | HHC (Primary Lead) | $40,141,876 |
| HIP/Emblem | New York City Health and Hospital Corporation | HHC (Secondary Lead) | $26,078,192 |
| United Health Plan | Maimonides Medical Center | Wyckoff Heights Medical Center | $19,992,400 |
| MVP/Hudson Health | Montefiore Hudson Valley Collaborative | Montefiore – New Rochelle | $7,803,629 |
| | Westchester Medical Center | Health Alliance (Benedictine) | $2,973,814 |
| Fidelis | Maimonides Medical Center | Interfaith Medical Center | $26,944,018 |
| | | Kingsbrook Jewish Medical Center | $26,944,018 |
| | Montefiore Hudson Valley Collaborative | Montefiore – Mount Vernon | $11,050,949 |
| | | Nyack Hospital | $2,903,886 |
| | Nassau Queens Performing Provider System, LLC | St. John's Episcopal | $7,724,637 |
| | Refuah Community Health Collaborative | Good Samaritan Hospital Suffern | $2,308,021 |
| | Westchester Medical Center | Ben Secours Charity Health | $4,702,450 |
| | | Good Samaritan Hospital Suffern | $2,130,481 |

## DEVELOPMENTAL DISABILITIES INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATION (DISCO)

A Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) is intended to be a specialized care management model for people with intellectual and/or developmental disabilities (I/DD). Currently, the I/DD population is carved out of Medicaid managed care. A DISCO would be a new organization formed by current Office for People with Developmental Disabilities (OPWDD) providers, representing a provider network for OPWDD services, which would provide care coordination services for its enrollees. The DISCO program would be piloted on a voluntary basis for several years before becoming mandatory for all OPWDD Medicaid recipients. Many other aspects of the DISCO program, such as the service package, organizational structure, payment model, and rates, are still under development.

## OPWDD Transformation Panel

The OPWDD Transformation Panel is a group of stakeholders that OPWDD has convened to advise on the implementation of OPWDD's Transformation Agenda. The Transformation Agenda, also called the OPWDD Road to Reform, is an initiative to modernize the I/DD service system and create a more person-centered approach by encouraging increased employment options, self-direction options, transitions into community-based residential care, and managed care for people with I/DD.

The Panel's main tasks include reviewing proposals for the transition to managed care and discussing the design of the DISCO program. The Panel also holds forums to receive input from the general public. It is expected to release a set of recommendations for the DISCO program in early 2016.

# FULLY-INTEGRATED DUALS ADVANTAGE (FIDA)

The Fully-Integrated Duals Advantage (FIDA) demonstration is a managed care model which implements specialized health plans that provide a comprehensive Medicare and Medicaid benefit to dually-eligible adult individuals who reside in a nursing home or need more than 120 days per year of long-term care. FIDA plans cover all health care, behavioral health, long-term care, and all other benefits included in the Medicare and Medicaid service packages. They also provide care management through an interdisciplinary team (IDT) model. About 170,000 dually-eligible individuals living in an eight-county region (New York City, Long Island, and Westchester County) are eligible to join a FIDA plan.

Enrollment in FIDA plans began in 2015 in New York City and Nassau County. To date, enrollment has been lower than expected, with a total of 7,540 members enrolled by November 2015, while over 50,000 individuals have opted out. As of January 2016, a total of 17 plans are participating in the program, although five plans have dropped out. As a result, the State has implemented reforms to the program intended to improve flexibility, simplify procedures, and reduce administrative burdens for enrollees, plans, and providers. The State and CMS are also reviewing payment rates, with the possibility of rate increases for 2016. Passive enrollment has been suspended until further notice, and enrollment in Suffolk and Westchester Counties has been postponed until the second half of 2016. The State will monitor the effects of these changes in 2016 and will make more changes as needed.

## FIDA for Intellectual and Developmental Disabilities (FIDA-IDD)

In November 2015, CMS and New York State announced the FIDA-IDD model, which expands on the original FIDA demonstration to create a specialized managed care option for dually-eligible adult individuals with intellectual and developmental disabilities (I/DD). People with I/DD are not eligible for the original FIDA program.

The State and CMS intend to contract with one organization, Partners Health Plan, to operate the first pilot FIDA-IDD plan. The plan may enroll up to 10,000 dually-eligible individuals with I/DD in a nine-county New York downstate region (New York City, Long Island, Westchester County, and Rockland County). Like the original FIDA, the FIDA-IDD plan will cover all services included in the Medicare and Medicaid service packages. The FIDA-IDD plan will receive per member per month (PMPM) capitated payments and possibly financial performance-based incentives in later years.

The State is still collaboratively developing some program design elements for the FIDA-IDD. Enrollment is scheduled to begin no sooner than April 2016.

## HEALTH HOMES TO SERVE ADULTS

A Health Home is a care management service model for Medicaid-eligible people with chronic health conditions. The program currently serves individuals over the age of 21. Under this model, a care coordinator working for the Health Home or a contracted agency helps members access all of the services they need, and facilitates communication and coordination among all of that individual's caregivers. Health Homes are collaborations between a number of organizations, including community providers, health plans, and other community-based organizations. Health Homes are required to provide the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family support services; referral to community and social support services; and use of health information technology to link services. Health Homes receive a capitated per-member per-month payment. Medicaid members who have at least two chronic conditions, HIV, or a SMI may be enrolled in a Health Home. Individuals with developmental disabilities and those receiving more than 120 days of long-term services and supports (LTSS) are excluded. As of December 2015, there are approximately 116,000 unique members enrolled by Health Homes. The program is currently operating statewide.

## HEALTH HOMES TO SERVE CHILDREN

The Health Home program is being expanded to serve children up to age 21. Children's Health Homes are designed to provide youth- and family-driven care coordination. Children who are enrolled in Medicaid and 1) have at least two chronic conditions, 2) HIV, or 3) a Severe Emotional Disturbance (SED) may be eligible to enroll in a children's Health Home. Pending approval from CMS, exposure to "complex trauma" will be added to these eligibility criteria.

Children's Health Homes will provide the same six core services as Adult Health Homes, but they will be specifically tailored to serve the needs of children and their families. The enrollment phase is expected to begin in September 2016.

## MEDICAID STATE PLAN AMENDMENT (SPA) SERVICES FOR CHILDREN

As part of the transition to managed care, new Medicaid SPA services are being proposed for children eligible for Medicaid. These new services include:

- Crisis Intervention;
- Community Psychiatric Supports and Treatment;
- Other Licensed Practitioner;
- Psychosocial Rehabilitation Services;
- Family Peer Support Services; and
- Youth Peer Advocacy and Training.

These services will be implemented as soon as possible, pending CMS approval. The guidance document is expected to be released in 2016 and will include more details on the services. Services will initially be available on a fee-for-service basis, but will transition into Medicaid Managed Care in 2017.

## NEW YORK STATE HEALTH INNOVATION PLAN (SHIP)

The State Health Innovation Plan (SHIP) is a plan that New York submitted to the CMS Innovation Center as

part of the federal State Innovation Models (SIM) program. Through this initiative, New York will receive $99.9 million in federal funding over four years to implement initiatives that improve statewide access to care across all payers. The SHIP's goal is to enhance and bring to scale a model similar to the patient-centered medical home, supported by a value-based payment system. In that way, the SHIP and the DSRIP programs are intended to be complementary, with SHIP supporting the expansion of value-based primary care for both Medicaid and non-Medicaid providers while DSRIP focuses on transformation of safety net providers. The SHIP funding will be used to implement the following initiatives:

1. Transform primary care practices on a regional basis to prepare for adoption of the Advanced Primary Care (APC) model;
2. Expand value-based care to 80% of New Yorkers by 2020;
3. Support workforce performance improvement through professional education and training;
4. Integrate APC with regional population health;
5. Develop standard quality metrics and enhanced analytics; and
6. Provide state-funded health information technology.

### Advanced Primary Care (APC) Model

The Advanced Primary Care (APC) model will be an extension of the patient-centered medical home (PCMH) primary care model. APC will provide patients with integrated, team-based care. The model is defined in terms of the following four components:

- A defined set of practice capabilities that promote integrated care and care coordination;
- A set of core measures to ensure consistent reporting and incentives;
- Common milestones, linked to payments, that define a practice's capabilities over time; and
- Outcome-based payments that support team-based care and allow for shared savings.

About $67 million of SHIP funding will be available to provide practices with technical assistance in transitioning towards APC models and achieving APC milestones. The State intends to work to promote participation in the APC by all major payers, including Medicare, Medicaid, the New York State Health Insurance Program, and commercial payers, including self-insured arrangements.

In early 2016, the State intends to issue a Request for Applications (RFA) to select practice transformation vendors who would start providing assistance to practices by the second quarter of 2016. APC-compatible contracts would start to be available in the second half of 2016, with the majority beginning in 2017.

## PATIENT-CENTERED MEDICAL HOME (PCMH)

The Patient-Centered Medical Home (PCMH) is a primary care model under which each patient has an ongoing relationship with a personal physician and a team of providers. PCMHs are expected to provide the majority of a patient's health care needs and to provide care coordination for other required services. They are also held accountable for a set of quality measures and must achieve meaningful use of electronic health records (EHRs).

In New York, PCMH practices generally seek recognition by the National Committee for Quality Assurance (NCQA) because the Medicaid program offers incentive payments to NCQA-recognized PCMH providers.

Providers may achieve one of three levels of recognition, with Level 3 the highest. Since the initial release in 2008, the NCQA has updated its standards twice, most recently in 2014. As of January 1, 2016, incentive payments will be decreased (see pg. 23) for practices meeting the 2011 standards and increased for practices meeting the 2014 standards.

## TRANSFORMING CLINICAL PRACTICES INITIATIVE (TCPI)

The Transforming Clinical Practices Initiative (TCPI) is a federal learning initiative by the CMS Innovation Center that will help clinicians share, adapt, and develop comprehensive quality improvement practices. Under the TCPI, organizations will develop Practice Transformation Networks to provide peer-to-peer technical assistance and learning opportunities for clinicians to develop skills related to practice transformation.

The CMS Innovation Center announced awards in September 2015. Three networks will operate wholly in New York: the National Council for Behavioral Health, which will receive up to $7.7 million; the New York eHealth Collaborative, which will receive up to $48.5 million; and the New York University School of Medicine, which will receive up to $6.9 million. Each grant will last for four years.

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# KEY DATES

## DSRIP

| Activity | Date |
|---|---|
| Bi-Annual PAOP Meeting | January 21-22, 2016 |
| Second Performance Payments Disbursed to PPSs | Late January 2016 |
| DSRIP Year 2 Begins | April 1, 2016 |
| Third Performance Payment Disbursed to PPSs | Late July 2016 |

## Managed Care Reform Implementation

| Activity | Date |
|---|---|
| BH HCBS Services Implemented for Adults in NYC | January 2016 |
| BH Non-HCBS Services Carved In for Adults Outside NYC | July 2016 |
| Children's Health Homes Begin Enrollment | September 2016 |
| BH HCBS Services Implemented for Adults Outside NYC | October 2016 |
| BH Services Enter Managed Care for Children in NYC | January 2017 |
| BH Services Enter Managed Care for Children Outside NYC | July 2017 |

## VBP Roadmap

| Activity | Date |
|---|---|
| Hospitals Submit Draft QIP Plan to PPS | January 15, 2016 |
| PPSs Return QIP Plan to Hospitals | January 29, 2016 |
| Hospitals Submit Final QIP Plan PPS and MCO | February 12, 2016 |
| PPS and MCOs Approve QIP Plans | February 19, 2016 |
| Hospitals Submit First Quarterly Report on QIP | April 30, 2016 |