Medicaid Redesign Team Structural Roadmap:

Roles and Responsibilities in a Value Based Payment World

New York State (NYS) Medicaid is on a multiyear path to help reshape and improve the care system for Medicaid members. Since 2011, over 389 Medicaid Redesign Team (MRT) projects have been launched with the specific goal of improving care and increasing efficiency of the Medicaid program. While past success is clear, the present and future are brimming with additional challenges stemming from the aggressive goals in the State's Medicaid Redesign Team (MRT) waiver and complicated by federal efforts to reshape Medicaid and indigent care funding.

Future-proofing the health care delivery system requires an orchestrated effort from the set of actors that operate between the State and the direct providers of service to assist both the patient and providers to ensure the most cost-effective care is provided. This critical "middle layer" of actors, which includes Managed Care Organizations (MCOs), Managed Long Term Care Plans (MLTC), Health Homes (HHs), Performing Provider Systems (PPS), Accountable Care Organizations (ACOs)/Independent Practice Association (IPAs), Behavioral Health Care Collaboratives (BHCCs), Patient Centered Medical Homes (PCMH), Qualified Entities (QEs), and Coordinated Care Organizations (CCOs), must have their roles in the health care delivery system clearly defined relative to the overall mission to collectively succeed. The middle layer exists between the State, who is at the top and trying to purchase access, quality and efficiency from a more integrated system of care and the service providers, who are on the front lines, who often struggle to balance meeting patient needs and managing the complexity associated with the current health care delivery system.

This document seeks to clearly define the various roles that critical middle layer actors play in a reformed system that is evolving to become more responsive to both patient and provider needs. Critical to this effort will be understanding how these various parties work with other clinical and social service providers in the new paradigm where high performing networks begin to aggressively replace disconnected service silos.[1]

Medicaid Managed Care Organizations

NYS Medicaid will continue its effective reliance on mainstream Managed Care Organizations (MCOs) to carry out much of the day-to-day service access and accountability work for their enrolled members. Over 4.7 Million individuals (77% of Medicaid Members) are enrolled in

[1] For a more in-depth overview of the various roles and responsibilities envisioned across the care delivery spectrum, please refer to Appendix A.

managed care as of December 2017. Mainstream MCOs, Managed Long Term Care (MLTC) Plans, Health and Recovery Plans (HARPs) and other specialty plans are key players in contracting and quality management relative to VBP.

The NYS Medicaid Managed Care program through its contracted MCOs has propelled NYS to the head of the pack on standardized measures of quality – NYS now exceeds national commercial benchmarks on many measures. Access for Medicaid members have greatly improved throughout the State. Despite that very promising quality advancement, much more work needs to be done, especially with regards to better managing our highest risk populations, reducing avoidable events, and better integrating care more generally and achieving more person-centered service delivery. Health Information Technology (HIT) tools are providing the next major step forward relative to quality insights at the provider level. HIT tools can integrate available patient information from different sources and deliver this invaluable data to the provider as they are seeing the patient. This data integration provides a more holistic record of the patient's experience within the overall health system and empowers the provider to prescribe timely and appropriate care with better coordination of other providers for the patient's needs. Bringing together providers and health plans is essential to moving forward in health care transformation.

The role of the health plan in the future state will continue to be member enrollment and services, network development and contracting for capacity and access, quality and utilization, management. However, as envisioned under Value Based Payment, plans will begin to delegate some risk, network development, and care management activities to increasingly sophisticated networks of providers that have been purposefully designed to better manage population health under VBP arrangements. Accordingly, plans must continue to support local PPS, VBP pilot contractors, and other developing ACOs and IPAs that are forming both vertically and horizontally integrated networks of hospitals, nursing homes, physician practices, and specialty providers like behavioral health and cardiology.

Building a higher performing health care delivery system requires more collaboration between parties to reach higher levels of performance and achieve quality health outcomes. Health plans and providers can build new, less adversarial and more collaborative relationships when moving from the paradigm in which the health plan is primarily viewed as a resource controller, to one in which the plan is partner with providers to achieve effective service utilization management through performance and health outcome management. This ability for providers to partner with plans in VBP arrangements will move providers that are now focused on creating service volume to maximize revenue, to partner with plans as a co-manager of quality improvement, efficiency, and better value in service delivery. As part of this new role, all Medicaid health plans should assess the level of effort they are currently dedicating to traditional service authorization and utilization management versus the resources currently deployed to support development, operation and oversight of these new VBP consuming entities and using plan resources to help PPS and providers build more future-facing services like telemedicine or mobile home visiting. For instance, plans must begin to share their data (e.g., claims, gaps in care reports, population health tracking, risk-based alerts etc.) with PPS

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and VBP contractors. Further, more sophisticated data exchange should be enabled between health plans and population health support entities like Regional Health Information Organizations (RHIOs)/QEs to begin to unleash the power of both claims data and more real-time medical record data coming from Electronic Health Records (EHRs) and other patient management platforms.

For VBP to work, value must be measured by increasing sophisticated performance measures of access, efficiency, clinical quality, and outcomes. Historically, MCOs have played a critical role in the process of closing gaps in care measured at both the plan level and at the provider level. This capability must be leveraged and enhanced as part of the move to VBP. For instance, chart review should move from a largely manual process of patient/condition samples to more robust e-reporting of measures at the VBP contractor level from EHRs. While the State has engaged clinical advisory groups (CAGs) to select and align measures, durable barriers still exist to measurement at the provider level that are best solved by the collective efforts of health plans, QEs and EHR vendors all working together with the State to improve access to more timely and relevant quality and efficiency data.

Further, care management is vital to the success of any quality improvement effort, especially in Medicaid, with so many of our enrolled members living with behavioral health conditions, functional limitations, and cognitive and physical impairment. Traditionally, plans have operated telephonic care management capacities and have contracted with individual practices to delegate some of this critical function. In 2012, the Medicaid program sought to enhance and centralize provider level accountability for care management by implementing Health Homes (HHs) for Medicaid's highest need, highest cost members that requires a more intensive, comprehensive, person-centered approach to care management than Plans are equipped to provide. While this move was controversial and the development of the Health Home care management model and program has been challenging, there now exists a robust statewide network of HHs working with downstream care management agencies to provide care management for the highest risk adults and children with centralized tracking and statewide oversight on performance and quality. While most HHs that have matured their operations are doing a better job of delivering this critical service to traditionally hard-to-serve and engage Medicaid members, there are HHs and a handful of care management agencies (CMAs) that have not performed as well and are not currently meeting statewide standards. The State is taking a more aggressive posture toward quality management (and will shortly transition this function to the Medicaid MCOs) to assure that only higher quality providers are authorized to do this critical work. In fact, since the inception of the Health Home program in 2012, the State has closed 5 HHs due to operational challenges and/or performance issues. Despite these challenges, Health Homes have been a key element in the State successfully achieving its federally required reductions in avoidable hospitalizations.

The State is making two critical changes that will incentivize plans to more closely partner with HHs, actively manage linking their Plan members to HH, and managing the quality and efficiency of the care management services delivered by the HHs. First, in April 2018, the flow of HH payments will shift from payments made by the State directly to the HH, to payments

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made directly from the Plan (though an adjustment to the plans' capitated rate) to the HH. Plans will have the power to leverage HH payments to performance manage and reward high performing HHs that effectively reduce unnecessary costs and improve health outcomes of their high cost members. Second, the State is ramping up a Health Home Quality Performance and Management program, including dashboards for HHs, Plans and Care Managers, and statewide transparency into key performance indicators, including HH enrollment and retention rates, potentially preventable visits and readmission rates, and increases in primary care access, and other services, as well. The combination of plans paying HHs directly with powerful performance tools in place will give plans the resources to more effectively partner with HHs around performance management. The HH care management infrastructure that is critical to ensuring intensive care management is available to Medicaid's highest needs members.

Given the significant investment in Health Homes and the growing maturity of this capacity, Plans are now expected to fully delegate care management responsibility for HH eligible and enrolled members to HHs. Plans will be required by contract with the State to delegate this responsibility and to submit a plan for approval by the State relative to the implementation of such delegation and increased performance management. Some plans have developed mutually agreeable shared responsibility for care management with HHs (e.g., plan manages Primary Care Practitioner (PCP) aspects of care plan, HH manages behavioral health and other specialty care in a coordinated fashion) and such arrangements can be supported with specific approval by the State and with the concurrence of the HH. In return, HHs must support plan VBP goals by moving to value and risk-based contracts as described in the HH roles below.

To view a list of mainstream MCOs by county, click here.

Managed Long Term Care

For the Managed Long Term Care (MLTC) subpopulation, MLTC Plans have historically provided high levels of care management for Medicaid members with a need for long term services and supports. Through a partially capitated product, and three fully capitated and integrated products (Programs of All-Inclusive Care for the Elderly (PACE) the Medicaid Advantage Program (MAP), and the Fully-Integrated Dual Advantage (FIDA)), the 67 MLTC Plans serve as a vital link of care between the various providers of care and Medicaid members. MLTC Plans will have a significant role in the development of VBP initiatives by continuing to serve as the source of care management, but also in developing relationships with and between the various providers of care, working with the State in obtaining and releasing data, and serving as a conduit for innovations in VBP design amongst providers.

In particular, MLTC Plans should take a lead in motivating long term care providers to interact and contract with other long term care providers, as well as all other providers of care. In this environment, there should be a natural progression for long term care providers to engage in formal contractual relationships. These larger entities will take on larger amounts of risk with the goal of creating total costs of care arrangements. For the fully capitated and Medicaid/Medicare integrated products, namely PACE, FIDA, and MAP, the goal of being VBP

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ready will focus on entering into total cost of care arrangements for Medicaid services. MLTCs are already engaging in such contracts, or have better potential to achieve this goal in a relatively short amount of time.

In collecting and providing data, the role of the MLTC Plans will be to ensure that they are correctly reporting relevant data to the State from all the sources of data collection (i.e. the UAS system, Encounter Data, Cost Reports, etc.) It will be the responsibility of MCOs to collect and report very accurate data, some of which will be critical in determining measure levels and performance. MCOs should utilize State tools and dashboards with the goal of understanding their plan-level performance and other metrics that emphasize value. In turn, MCOs should also be sharing data with their providers, and provider organizations to ensure that there is streamlined access to quality data that highlight measure levels and performance. The State will increasingly look to MCOs to perfect their data sources and reporting activities with the State and their providers.

MLTC Plans should collaborate with all providers to ensure that all levels of care are value based. The partially-capitated product relies on care management and therefore the role of the care managers should emphasize that continued care and quality is matched to the needs of the patient. Care managers, and the MCOs overall, should actively engage in care coordination with an interdisciplinary focus. Therefore, outcomes of care coordination should move beyond episodic determinations and evaluations, and should include a holistic view on member care. For the fully capitated products, which have a more interdisciplinary focus as an inherent part of the product design, there should be a movement to more innovative approaches to care that examine the highest value and best outcomes for their members.

MLTC Plans should also actively engage the State with innovative solutions and ideas that they develop. The key to improving the outcomes for MLTC members, as well as to improve value, is that best practices in care delivery, contracting, and measures, among other areas, are shared and cultivated. The State values innovative solutions, and welcomes thoughts around performance pilots, and other quality-driven demonstration that can be replicated throughout the MLTC system.

To view a list of MLTC Plans by county, click here.

Health Homes

As noted above, with the inclusion of the Health Home (HH) payments in plan capitation rates, HHs will be required to take full care management responsibility for high risk Medicaid members with multiple chronic conditions, serious mental illness and HIV. There are 33 designated HHs located throughout NYS. Out of the 33 designated HHs 13 are designated to serve children and adults, 17 are designated to serve adults only, and 3 are designated to serve children only. Children's designated Health Homes began operating in December 2016.

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Current HH enrollment statewide totals almost 175,000 enrollees and another 43,000 are in outreach. As part of this responsibility HHs have a role in assuring that all enrolled members receive quality care management from the Health Home care management agencies (CMAs) they contract with to provide care management and develop individualized care plans in collaboration with the member, and their family, and in accordance with HH standards and requirements and Plan requirements. MCOs are required to contract with Medicaid HHs under Administrative Services Agreements, to deliver care management for their members that meet HH eligibility criteria and choose to enroll in Health Homes. While care management continuity provisions apply, MCOs have not been required to contract with all HHs and may select the highest quality HHs for their members to choose among. This, coupled with VBP requirements, means that to remain competitive and viable, all HHs need to prioritize the quality of the care management experienced by their members enrolled in downstream CMAs.

Recent re-designation visits by the Department of Health (DOH) identified some excellent quality management and solid oversight practices by most HHs. However, the re-designation process also identified a few HHs that clearly need to improve their infrastructure and quality management approach to better supervise, manage and assist their downstream CMA partners to assure enrolled members receive optimal care. Standardized measures/indicators of care management quality/performance also show variability among HHs. MCOs over time will be moving members from lower performing HHs and CMAs to make sure their members are best served. This means that now is the time for HHs to immediately take concrete measures to close any performance gaps. Measuring how well Health Homes perform may be a complicated process given the nature of the eligible HH population (i.e., "risk adjusting" the population) and will require Plans and Health Homes to work closely together to ensure there is both quality and capacity for Health Home care management.

Many HHs and CMAs have engaged significant resources in lower value outreach efforts like letters and phone calls. While outreach is clearly an important line of work, significant focus must remain on improving the process of identifying and enrolling members by restructuring the delivery of outreach work in smarter ways. Some of the performance leading HHs and PPS are employing more promising outreach techniques such as utilizing peer navigators and stationing outreach workers in high risk locations like Hospitals, EDs, shelters and the criminal justice system. The pivotal link to successful outreach will rely heavily on the managed care and HH partnership aligning real time data and predictive risk modeling to prioritize the highest risk individuals for outreach. To date, this type of partnership across the Plans and Health Homes has not been embraced statewide.

Since Medicaid MCOs will be fully delegating care management responsibility to HHs, the lead HH and downstream care management agency must assure that all enrolled members have a care plan that is member-centric and person-centered, comprehensively addresses the 360-degree integrated view of all members' needs. Care managers must be actively engaged in closing all gaps in care needs identified by that comprehensive person- centered plan of care. Further, all HHs and CMAs must assure that CMAs are qualified to meet the member's needs, member caseloads, and the intensity of care management services (including face-to-face

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meetings) are sufficient to address member needs. Lead HHs, working with MCOs and VBP contractor networks, should be assisting downstream CMAs with any service access gaps or durable coordination and communication issues that are emerging as threats to the viability of member care coordination and service continuity. That continuity includes arranging access to and communication between social determinate type services such as housing, healthy food, education, etc. Generally, Health Homes are responsible for making sure each enrolled Medicaid member gets the care and wraparound services they need and that such care/services are delivered and coordinated effectively and reflected in the member's comprehensive Health Home care plan.

As mentioned in the MCO section above, Health Homes will be required to support MCO VBP goals by moving to value based arrangements with progressive risk over time based on HH readiness. Children's Health Homes and OPWDD CCOs would not be envisioned to move to risk based contracting any time soon. For adult non-DD HHs to begin this movement to VBP contracting these HHs must be contracted at least at VBP level one (upside only risk) by 1/1/2019. This level one contract will be based on total cost for all adult non-DD attributed members to that Health home. This will most likely be contracted directly from the MCO but can be achieved through a subcontract as part of a larger VBP deal with an IPA or other provider group contracting for total cost or subpopulation cost at any of the three VBP roadmap levels.

To view a list of HHs by county, click here.

Performing Provider Systems

New York currently has tasked 25 Performing Provider Systems (PPS) across the State to establish local provider partner collaborations to implement projects designed to reform service delivery, improve care, address community health needs and reduce avoidable hospitalizations.

To carry out these important functions, the PPS have developed a collaborative network with the goal of a local integrated delivery system connecting providers across the continuum of care to foster patient-centered care. PPS have built deep population health management capabilities including data management, patient tracking, practice redesign, community engagement, provider connectivity, and service integration. They have developed partnerships with community-based organizations (CBOs) to assist with patient navigation and social determinant risk factors. These capabilities will be critical to leverage in supporting local efforts to implement VBP. In fact, the State is tasking each PPS with the development of a local PPS sustainability plan which must include how the PPS intends to support its assigned catchment area with the successful implementation of VBP, even after the expiration of the Delivery System Reform Incentive Payment (DSRIP) Program waiver in 2020. In that sustainability plan the PPS must indicate how they plan to help the State and all the actors in value-based services design more effectively carry out their respective roles. In fact, if a PPS does not plan to continue as an entity post MRT waiver in 2020, it must describe how it will transfer its

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infrastructure to others in the community so as to ensure that these vital population health organizational functions are retained.

This "population health facilitator" role of VBP support can take many forms. PPS can offer management services to ACOs, IPAs and other VBP contracting networks to assist them with data management, practice redesign, rapid cycle continuous quality improvement, care management support and more. PPS can also directly form (as a whole or as sub-hubs) into IPAs or ACOs to utilize all or a portion of their PPS network to contract with health plans as a VBP contractor or utilize CBO network in addressing social determinants of health. Some PPS are already serving as a neutral broker for various provider groups (e.g., physician IPA and behavioral health IPA, hospital network and physician IPA, Nursing home and home care agencies) to come together to explore joint VBP partnerships aimed at successfully managing higher-risk Medicaid populations. PPS can also contract directly with MCOs to deliver value-add services, such as deploying a better ground game in assisting local provider networks with improving quality and increasing efficiency.

PPS should be actively engaging community stakeholders now in determining exactly how they as the PPS (or a designated surrogate successor) will fit into the local superstructure of care. In other words, the PPS have the responsibility to drive to community consensus on how they, the PPS, will work in the future with MCOs, ACOs, IPAs, HHs, PCMH practices, and QEs in fulfilling this community "population health facilitator" function.

As referenced in the MCO roles section, DOH is expecting that MCO and PPS partnerships will deepen to support providers and their VBP networks in VBP roll out. MCOs are expected to share their data with PPS as the PPS continuously work with QEs and providers to create more real time patient management, tracking, and quality improvement capabilities. As part of this closer partnership, PPS can also help MCOs with closing needed local service gaps. For example, PPS can work across multiple MCOs to build more telehealth capacity in certain communities to improve access to specialty care and/or reach underserved populations. A close PPS/MCO partnership will help the MCO improve its quality and efficiency scores, which will help the MCO fare better in new percent-of-premium based quality and efficiency scoring. Similarly, downstream providers and PPS VBP earned resources will increase as local performance measures on both quality and efficiency improve.

To view a list of PPS by county, click here.

Accountable Care Organizations/ Independent Practice Associations

Many providers have formed or are in the process of forming specialized arrangements to deliver more accountable and value-based care through Accountable Care Organizations (ACOs), Independent Practice Associations (IPA), or similar arrangements. Many of these entities, whether set up to provide care for Medicare, Commercial and/or Medicaid members, have the goal of providing better population health management, reducing cost, and returning value to member/partner organizations and the patients attributed to them. These

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organizations are being set up both horizontally (groups of allied practices like Primary Care Providers (PCPs), or Behavioral Health Providers) and vertically (hospitals and physicians in one unified network)), and some horizontal networks are starting to affiliate vertically (behavioral health IPAs joining forces with physician PCP IPAs).

This "pre-integration" organizational work is an extremely valuable asset to leverage in the move to reward value and efficiency through VBP contracting. Individual doctors, specialists, nursing homes, smaller hospitals and behavioral health practices cannot prudently enter risk contract alone. However, by joining forces with other entities they can: 1) develop more shared service capacities like population health management and care management; and 2) spread risk across a larger population base with more shared tools to manage care and cost outliers. While competition is still critical to any balanced market including health care, better clinical integration through larger network development and shared services has been shown in some studies to reduce cost without reducing access.

All MCOs are already working with these organizations to progress primary care and hospital value based contracts, but even more of this is expected as behavioral health, specialty services, and long-term care begin to integrate more through IPAs and ACOs to offer value based and episode based contracts envisioned by the VBP roadmap. Several PPS are working with IPAs and ACOs to deliver more integrated behavioral health and primary care for some of the highest risk and highest cost Medicaid members. This work in some areas is being accomplished by behavioral health IPAs joining physician IPAs to work toward joint contracting for these higher risk populations.

Behavioral Health Care Collaboratives

Behavioral Health Care Collaboratives (BHCC) are provider networks led by licensed/certified/designated OMH/OASAS/BH HCBS agencies, delivering behavioral health services to integrate care across the entire spectrum of physical and behavioral health services. BHCCs are part of the new paradigm of high performing networks beginning to replace disconnected service silos.

BHCCs will focus on two overarching goals:

1. Preparing the participating BHCC health providers to engage in VBP arrangements by facilitating shared infrastructure and administrative capacity, collective quality management, and increased cost-effectiveness; and
2. Encouraging VBP payers, including but not limited to MCOs, hospitals, and primary care practices, to work with BHCC providers who demonstrate their value as part of an integrated care system.

As BHCCs mature they will begin to collaborate with primary care and hospitals to better manage population health under VBP arrangements. BHCCs will enhance quality care through clinical and financial integration and community-based recovery supports. They will promote

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integrated care (physical and behavioral) and attention to social determinants of health and prevention through community partnerships. As part of the population health management ecosystem in a given region BHCCs must work with the PPS and MCOs to advance this physical and behavioral health collaboration and integration. It is very important that BHCCs not duplicate existing infrastructure (especially IT capability) already built by PPS.

Funding will assist BHCCs in building infrastructure necessary to collect, analyze, and respond to data to efficiently improve Behavioral Health (BH) and physical health (PH) outcomes. BHCCs will use the resulting data collection, analytics, quality oversight and reporting, and clinical quality standards to improve care quality and enhance their value in VBP arrangements. The expectation is that BHCCs will leverage their shared expertise to be in a better position to enter VBP contracts. BHCC leads and network partners will ultimately participate in a Level 2 or higher arrangement as Level 1 provider networks or as a contracted entity in a Level 2 or higher arrangement**.**

The Patient-Centered Medical Home/Advanced Primary Care

The Primary Care Physician/Practitioner (PCP) is a pillar in the NYS health care system because they ensure comprehensive, continuous and coordinated primary and preventive care. Good primary care is foundational to optimizing the health of individuals. NYS has long championed the development of more robust primary care capacities through the development of Patient-Centered Medical Homes (PCMHs). Starting in July 2010, NYS began financial incentives in both managed care and Fee-for-Service (FFS) for practices meeting National Committee for Quality Assurance (NCQA)-recognized levels of PMCH. As of June 2017, over 2,260,993.2 Million Medicaid Managed Care patients were being served by 6,781 PCPs who were NCQA PCMH recognized.

Medicaid has a goal that all its MCO-designated PCPs be NCQA PCMH recognized and that they fully embrace the delivery of more integrated and value-based care. Medicaid will begin a process this year that will reduce (and eventually eliminate) any PCMH recognition funding for practices that decline to participate in VBP contracts at least at level one. Further, as part of the longer term VBP rollout and goal to improve patient quality, in the future, the State will pivot the per member, per month (PMPM) add-on to reward those PCMH practices who hit certain quality and efficiency targets consistent with the NYS VBP roadmap.

As referenced in DSRIP project plans, the State Innovation Model (SIM) grant, seeks to develop enough PCMH/ Advanced Primary Care (APC) capacity that all Medicaid patients could eventually have the choice to be served by one of these advanced practices either meeting NCQA or State APC certification standards. The State is also working with NCQA to align PCMH and APC into NYS PCMH which will ensure alignment among state programs and with federal and commercial programs. This will ensure all members, including those not meeting Health Home criteria, get access to higher quality, more integrated service delivery of physical medicine and behavioral health care. Importantly, these practices will also provide appropriate care coordination and patient navigation services, especially for those members struggling with

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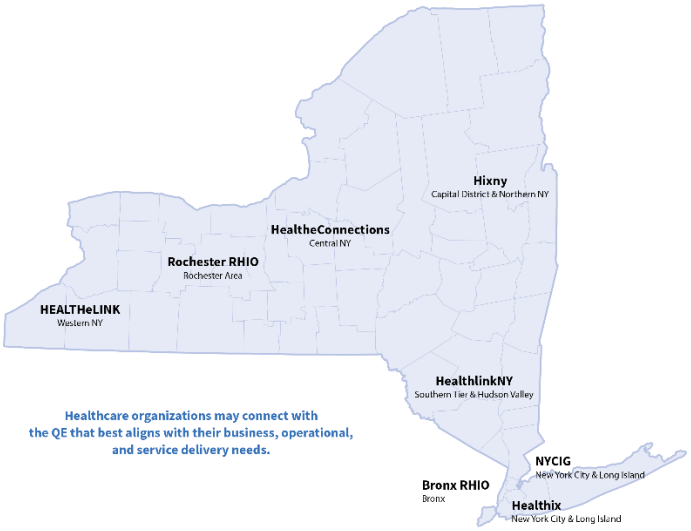
managing a chronic disease, social challenges, and potentially multiple specialty providers outside of their primary care visits.

It is expected these practices will assertively seek to work as part of integrated VBP networks to deepen their population health management capabilities including better clinical and social integration across hospitals, specialty practice, and social service type providers that participate in these broad horizontal networks. If such broad networks do not exist locally to serve Medicaid patients, D&TC, FQHC, hospital OPDs, and other PCMH practices serving Medicaid members can begin conversations with PPS, local IPAs and ACOs to try to forge such partnerships to contract more successfully in VBP arrangements.

As part of this, it is expected these PCMH practices will be part of their local Qualified Entity to further capabilities around information exchange, population health management support, and e-measurement so critical to value based payments.

SHIN-NY Support for DSRIP and VBP

NYS has been investing for several years in the development of the Statewide Health Information Network for NY (SHIN-NY). SHIN-NY is intended to be the Health Information Exchange (HIE) backbone to support health transformation initiatives included DSRIP and VBP. Formerly known as RHIOs, QEs are local HIE networks that support the exchange of the regions' information from electronic health records (EHR). There are eight QEs in NYS that cover different areas from Buffalo to New York City. These QEs, the Statewide hub supporting exchange across QEs and the set of regulations and legal agreements all comprise the SHIN-NY to enable exchange and provide the services that make secure, vital access to a patient's health information possible statewide.



This secure network allows providers to use Direct Messaging, Patient Record Lookup and Alerts. Direct Messaging functions like a highly secure email, giving clinicians the ability to

seamlessly exchange authenticated, encrypted, clinical data with one another. Patient Record Lookup is like a search engine, allowing healthcare providers to retrieve individual patient records from across the network based on state and federal consent requirements. Providers can also receive alerts about their patients, such as a notification that a patient has been admitted to an Emergency Room.

The DSRIP projects required connectivity to (and data exchange with, as appropriate) the local QEs to enable information exchange for coordinated care and to ensure availability of data statewide. As part of DSRIP currently, and central to VBP efforts for the future, the State is working with the QEs to help PPS with data management/information exchange and other population health workflow management. In many cases, cementing these relationships more firmly will allow for broader use of SHIN-NY data, which will help with data gap closing and data quality improvement.

Another important capability in VBP is more real-time performance tracking and quality measurement. There is a significant shift nationally in quality measurement where CMS, NCQA and the health care community are shifting from annual claims-based quality measurement to more frequent digital quality measurement based on data derived from EHRs. QEs are working in some regions to assist providers, PPS, and some MCOs by making clinical data available, at the request of providers, to PPS and MCOs for the purpose of care management and quality measurement. Specific to quality measurement, the State, New York eHealth Collaborative (NYeC) and QEs are exploring the digital quality measurement with the goal of replacing sample and record chase method of obtaining clinical information for measurement. Toward this end, the State is working with NYeC to identify a governance process that incorporates stakeholder input to define the data requirements for digital quality measurement and will be working with QEs to define processes to improving the quality and availability of EHR data for digital measurement. Additionally, some QEs are developing the infrastructure to provide proxy measures from HIE data to ensure providers have access to information for quality improvement. However, at the most basic level QEs will provide high quality data to providers, MCOs or anyone performing quality measurement.

QEs are working on a set of ambitious goals described in the SHIN-NY 2020 Roadmap to support care transformation and value based purchasing; NYeC will implement performance-based contract requirements for each of the QEs- focused on supporting value based care as one of five key strategies laid out in the Roadmap. With state support, QEs and the NYeC will be working hand-in-glove with PPS and MCOs, to help drive system improvement.

Further, consent management can be a major barrier for effectively implementing VBP. The QEs all have a managed consent process that can be leveraged and several are building network or community consenting that are implemented in the Health Home program to allow members to consent to allow their care team to access their information as necessary. For the QEs, focusing on high-quality and easily available EHR information will support real-time, actionable, high-performing population health management.

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Coordinated Care Organizations

This section will need to be developed.

Summary

New York seeks to make health care a team sport. The State seeks to forever banish the traditional siloes that made care navigation for patients difficult and in some cases impossible. The State firmly believes that integrated, collaborative care will lead to better health and life outcomes for Medicaid members. Value based payment is a powerful tool to help support health care system redesign and quality improvement. However, the goals of better service integration/continuity, improved quality, reduced cost, and increased patient responsiveness cannot be quickly reached without better orchestration between the various "middle layer" players in the health care system.

The purpose of this paper is to provide greater clarity on the roles and responsibilities of organizations in the "middle layer". The State hopes this document generates community-wide conversations and significant feedback so as to ensure all parties are on the same page as everyone moves forward into a value-based and integrated world.

Please send your feedback to this email address: VBP@health.ny.gov

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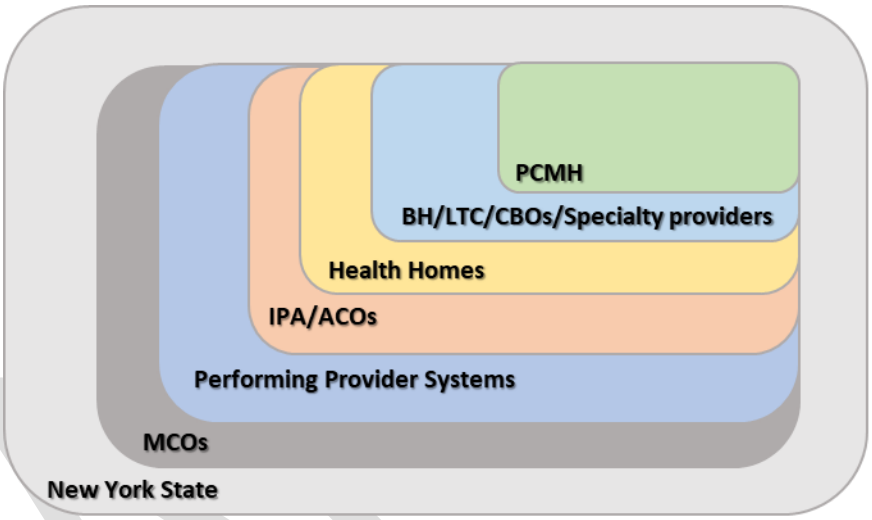
Appendix A

The following infographic helps to show the various relationships and roles in a new health care delivery system that is orchestrated around value. The graphic describes the various activities of each 'layer', organized between functions aimed at patient or provider support.

Care Delivery "Layers"



While it requires the entire spectrum of delivery partners to effectively manage the care of New York's Medicaid population, this document and graphic focus specifically on the following categories of care delivery participants: MCOs, Performing Provider Systems (PPSs), IPAs/ACOs, Health Homes, BH/LTC & Other Specialty Providers, and PCMH Primary Care Practitioners. The layers are organized hierarchically in the image at the right, but the actual interactions among the participants may shift and evolve to meet varying patient needs, adapt to relative systems' strengths and weaknesses in different geographies and environments, and incorporate new actors as the system matures.

Care Delivery Functions.

Each layer is responsible for supporting the other layers in the delivery spectrum by providing various functions, which may be generally categorized as either Patient Support or Provider Support Functions. Patient Support Functions are those with the end goal of supporting the patient themselves, and may include items from which the patient specifically and individually benefits or items benefiting the population as a whole. Provider Support Functions are those designed to support other providers/participants in the overall spectrum; these may include items which directly support individual providers, or provide structural support to the system as a whole.

Care Delivery Activities

The actual tasks carried out by participants in the Care Delivery Spectrum can be classified into one of the two functions outlined above – Provider Support or Patient Support Functions. For example, Risk Management (an activity) would be a Provider Support Function carried out by MCOs.

Layer	Patient Support Function(s)	Provider Support Function(s)
New York State		
MCOs	Manage Enrollment, Out-of-Network Benefits, Member Communication	Risk Management, Data Analysis, Provider Accountability, Utilization Review
Performing Provider Systems	Population Health Management	Provider Actionable Data, Facilitate provider Partnerships
IPAs/ACOs	Access to Integrated Care	Shared Services, Critical Contracting Mass
Health Homes	Support in Care Navigation	Hands-on Care Management
BH/LTC/Specialty providers	Specialized Care	Subject Matter Expertise
PCMH	Primary Care Quarterback	

The concluding graphic displays each activity within the layer responsible for that activity, and organizes those activities categorized as patient support vertically along the upper left section with those provider support activities presented horizontally along the bottom right.