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Project Narrative

I. Organizational capacity of applicant organization

Entity performing Cooperative Agreement activities under Notice of Funding Agreement (NOFO)

New York State's (NYS) Office of Health Insurance Programs (OHIP) will perform the Cooperative Agreement activities required under this Notice of Federal Opportunity (NOFO). OHIP reports to the NYS Department of Health (DOH) and serves as NYS' Medicaid Agency. In this capacity, OHIP administers the nation's second-largest Medicaid program, providing coverage to over 7 million Medicaid members and overseeing over $90 billion in annual expenditures.[1,2,3] The State's Medicaid program is comprised of nine divisions, with more than 950 staff members, 500 contracted staff, and 300 contracts.[4]

In addition to Medicaid, OHIP oversees the development and implementation of other key public health insurance programs in New York, including Child Health Plus for children under age 19 (CHIP), Elderly Pharmaceutical Insurance Coverage, and other health care financing programs (e.g., the Disproportionate Share Hospital program and the Health Care Reform Act). OHIP also works in close partnership with NYS' state-based marketplace, the New York State of Health (NYSOH), the Essential Plan (EP) for lower income adults, to include commercial payers providing coverage to EP members through Qualified Health Plans (QHPs)

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[1] Felland, Laurie, et al. Examining New York's Delivery System Reform Incentive Payment Demonstration: Achievements at the Demonstration's Midpoint and Lessons for Other States. 2018. https://www.medicaid.gov/medicaid/downloads/ny-dsrip-case-study.pdf

[2] Norris, Louise. "New York and the ACA's Medicaid Expansion." Healthinsurance.org, 20 Feb. 2022, www.healthinsurance.org/medicaid/new-york/.

[3] United Hospital Fund. "New York Annual Public Health Insurance | United Hospital Fund." United Hospital Fund, 2016, uhfnyc.org/our-work/initiatives/medicaid-institute/ny-public/annual/. Accessed 25 June 2024.

[4] "Department of Health, Commissioner's Cabinet." www.health.ny.gov, www.health.ny.gov/commissioner/cabinet_staff/.

via the NYSOH. Altogether, programs administered by OHIP provide health care access to nine million New Yorkers.[5]

NYS has experience implementing value-based payment (VBP) models for improving quality and controlling total cost of care (TCOC). In April 2014, NYS implemented its Delivery System Reform Incentive Payment (DSRIP) program, a collaborative, systemwide payment reform program to reduce avoidable hospital use by 25% and convert 80% of Medicaid Managed Care (MMC) payments into alternative payment arrangements.[5,6] To achieve these program goals, the State incentivized Performing Provider Systems (PPS)—integrated provider networks of primary care providers, required hospitals, and safety net providers such as Federally Qualified Health Centers (FQHCs)—to participate in DSRIP's delivery reform projects in system transformation, clinical improvement, and population-wide health promotion. By the end of its five-year demonstration period, DSRIP achieved a 26.1% reduction in avoidable hospital admissions and 18.1% reduction in preventable readmissions.[7] DSRIP met its goal of shifting 80% of its MMC spending into VBP arrangements.[8]

Since then, NYS has continued its commitment to transition Medicaid Managed Care Organizations (MCOs) and providers into a VBP environment. In 2022, the State further leveraged DSRIP's success through an updated VBP roadmap: *A Path toward Value Based*

[5]New York State Department of Health. NY DSRIP Project Toolkit New York State Delivery System Reform Incentive Payment Program Project Toolkit MRT DSRIP – Pathway to Achieving the Triple Aim |. 2014.
[6] "Value Based Payment Reform in New York State": Www.health.ny.gov, www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_alignment_paper_final.htm.
[7] Final Summative Report from 'Independent Evaluator for the New York State Delivery System Reform Incentive Payment (DSRIP) Program.' August 2022, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2021/docs/2021-08-24_final_summative_rpt.pdf.
[8] VBPTR administered by DHPCO and Extracted 8/10/2018

Payment, New York State Roadmap for Medicaid Payment Reform.[9] This roadmap established implementation specifications and contract requirements for all VBP arrangements in the state.

Investment in health care redesign for primary care

The State also has experience in primary care transformation initiatives. Since 2012, NYS has participated in numerous Centers for Medicare & Medicaid Services (CMS)-designed primary care models, including Comprehensive Primary Care Initiative (CPC), Comprehensive Primary Care Plus (CPC+), and most recently, Primary Care First (PCF). Through these programs, NYS increased chronic disease management care, preventative cancer screenings, and physician follow-up after emergency department (ED) visits or hospitalization, and reduced ED visits and hospitalizations.[10]

In 2014, NYS was awarded Center for Medicare & Medicaid Innovation (CMMI) State Innovation Models (SIM) grant to implement the State Health Innovation Plan, a roadmap to achieve the "Triple Aim" for all New Yorkers: improved health, better health care quality and consumer experience, and lower costs.[11] To meet these objectives, NYS implemented a state-based advanced primary care model in 2018 called the NYS Patient-Centered Medical Home (NYS PCMH), in partnership with the National Committee for Quality Assurance (NCQA). Through this initiative, the State aimed to promote a patient-centered primary care delivery model statewide.

To support the success of the program, NYS provided extensive technical assistance to primary care providers seeking NYS PCMH designation. As of 2023, 66% of MMC

[9] New York State Department of Health Updated Value Based Payment Roadmap. May 2022, www.health.ny.gov/health_care/medicaid/redesign/vbp/roadmaps/docs/final_exec_summary.pdf.
[10] Ayanian, John Z. "Transforming Primary Care through Innovations in Medicare." JAMA Health Forum, vol. 4, no. 12, 15 Dec. 2023, p. e235071, jamanetwork.com/journals/jama-health-forum/fullarticle/2813266?resultClick=1, https://doi.org/10.1001/jamahealthforum.2023.5071. Accessed 24 Jan. 2024.
[11] New York State Department of Health. New York State Health Innovation Plan. 2013. https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf

beneficiaries are assigned to primary care providers with PCMH designations.[12] As of June 2023, NYS had more practices and providers with PCMH designations than any other state, with more than 2,000 practices and 9,000 providers.[13] Primary Care States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model will align to this program (see *Section VIII. Primary care transformation and model* for further detail).

NYS plans to implement CMS' Making Care Primary model in counties north of Westchester in late 2024 to provide a pathway for primary care providers to improve care management and care coordination, leverage community-based services, and adopt prospective, population-based payments.

Key personnel

Amir Bassiri, Deputy Commissioner of OHIP and Medicaid Director, will serve as the Authorized Organizational Representative (AOR) for AHEAD. Darcie Hurteau, Director of Alternative Payment Methodologies in OHIP, will serve as the Project Director for AHEAD. Other AHEAD project staff will include key leadership from DOH. Key personnel includes: Michael Ogborn, Medicaid Deputy Director, OHIP; Kevin Wright, CFO and Director of Division of Finance and Rate Setting, OHIP; James Kirkwood, Chief Technology Officer, OHIP; Trisha Schell-Guy, Director of Division of Program Development and Management, OHIP; Sue Montgomery, Director of Division of Health Plan Contracting and Oversight, OHIP; Nicholas Asimakopoulos, Chief Data Officer, OHIP; Jackie McGovern, Director of Administration, OHIP; Kate Bliss, Bureau Director of Health Access, Policy, and Innovation, OHIP; Douglas Fish, Deputy Commissioner of the Office of Primary Care and Health System Management

[12] The New York State Medicaid / Child Health Plus Program Quality Strategy/ 2023. https://www.health.ny.gov/health_care/medicaid/redesign/docs/2023-2025_draft_chp_pub_com.pdf
[13] New York State Patient Centered Medical Homes Quarterly Report. 2023. https://www.health.ny.gov/technology/nys_pcmh/docs/pcmh_quarterly_report_june_2023.pdf

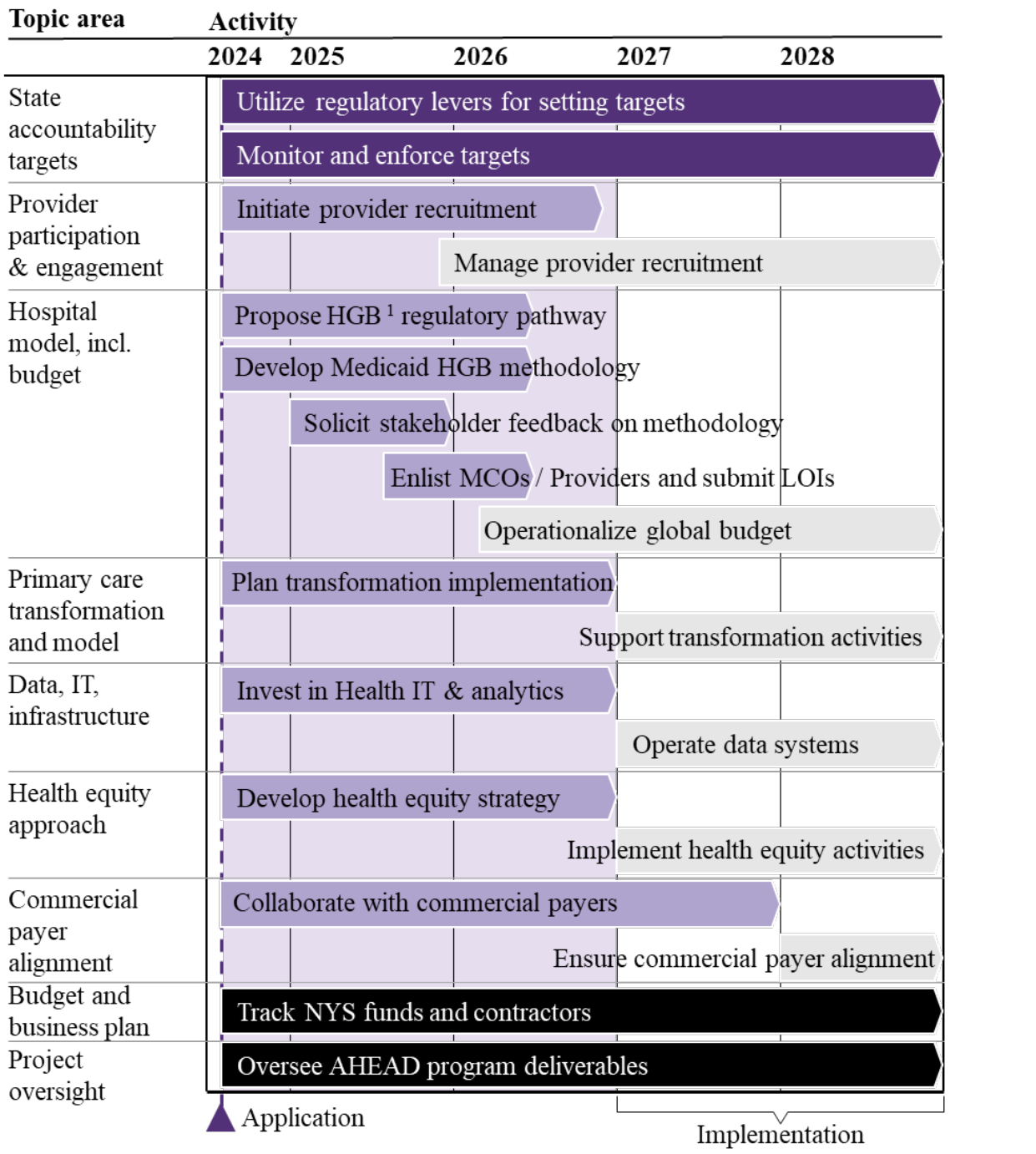
(OPCSHM); Lindsay Cogan, Deputy Director, Office of Health Services and Quality Analytics (OHSQA); and Danielle Holahan, Executive Director, New York State of Health (NYSOH). See *Resumes* in the Appendix for the relevant experience of key personnel, including the AOR and Project Director.

Both New York State full-time employees and contractors will support AHEAD Model activities. The State will primarily utilize contractors during the pre-implementation period from mid-2024 through 2026 to rapidly begin project operations. Contractors will support activities such as provider recruitment and engagement, hospital global budget methodology development, data and infrastructure enhancements, design of hospital health equity plans, and payer engagement. The State expects to be able to procure contractors to perform the necessary work in time for pre-implementation. The new full-time staff required to support the Model has been submitted for approval and is expected to be finalized prior to implementation.

The State will onboard new full-time employees such that there is a six-month transition between contractors and NYS full-time employees, where applicable. These employees will support ongoing model implementation, including setting targets and monitoring performance, operationalizing the global budget payment model, running the requisite reporting and data sharing, and managing provider engagement. The State currently estimates that the project will require 30-40 contractors and New York State full-time employees combined across pre-implementation and implementation periods. See *Organizational Chart* in the Appendix for a comprehensive breakdown of staffing and *Chart 1* below for a timeline of required activities and across contractors and NYS full-time employees. New York State full-time employees will primarily be staffed within OHIP, including from the Division of Finance and Rate Setting, Division of Program Development and Management, Division of Data Services and Analytics,

the Division of Health Plan Contracting and Oversight, and the Division of Strategic Operations and Planning. The State will also staff AHEAD project teams with individuals who possess specific subject-matter expertise from other DOH offices, including the Office of Health Services Quality and Analytics, and the Office of Primary Care and Health Systems Management. Other state offices such as the Department of Financial Services will support OHIP with commercial payer alignment to meet AHEAD operational and programmatic requirements.

Chart 1. NYS will require 30-40 contractors and New York State full-time employees to execute the AHEAD Model



[1] Hospital Global Budget (HGB)

Each topic area may be staffed with a Lead, Director, Manager, and/or Analyst. Leads possess executive-level talent with subject-matter expertise in their respective topic area and will provide strategic input to the team. Directors will provide strategic guidance in their respective topic area and provide supervision and oversight into day-to-day operations. Directors will lead a team of managers and analysts who will serve as the primary executors for their topic areas. Managers will be responsible for project management and the supervision of analysts. See *Job Descriptions* in the Appendix for information on NYS and contractor roles and responsibilities.

Reporting structure

All project staff members will report to Project Director, which will report to the AOR. See *Organization Chart* in the Appendix for a detailed description of the reporting relationships of key personnel.

II. Region definition

Description of sub-state region & rationale

The State intends to implement the AHEAD Model in five downstate counties: Bronx, Kings, Queens, Richmond, and Westchester and participation is encouraged for all hospitals located in these counties. These five participating counties were selected for their coverage of the state population and TCOC spend, diverse service population, prevalence of health disparities, addressable outmigration patterns, and presence of safety net hospitals. However, counties north of Westchester are ineligible to participate in Primary Care AHEAD given the State's participation in Making Care Primary in that region. The state is open to exploring sub-region expansion as additional model details become available. In addition to continuing conversations with hospitals in Manhattan and Long Island, the State is considering pathways to engage

additional hospitals both inside and outside of the currently identified sub-state region to both participate in the model and help mitigate the impact of outmigration.

NYS intends to implement the AHEAD Model in this sub-state region based on safety net hospital needs and hospital experience with health system reform. The State will leverage the AHEAD Model to support essential safety net providers serving Medicaid, Medicare, and uninsured populations. These safety net hospitals are financially vulnerable and have experienced significant declines in overall operating margins. NYS has received a letter of intent (LOI) from 13 hospitals (see *Section VI. Hospital Recruitment Plan* for additional information about LOI hospitals)—12 of which are safety net hospitals with deteriorating operating margins—to participate in AHEAD.[14] The sub-state region has experience in health care redesign; 14 of 25 Performing Provider Systems participating in DSRIP and 37% of NYS PCMH practices are located in this sub-state region.[15] Three safety net hospitals, Maimonides Medical Center, Montefiore Medical Center, and St. Barnabas Hospital (SBH Health System), previously participated in DSRIP Performing Provider Systems and submitted an LOI for AHEAD.[16]

Combined coverage of state population and total cost of care spend

Implementing the AHEAD Model in the sub-state region will impact a sizable portion of NYS' population and TCOC spend. As of April 2024, approximately 40% of the State's overall population, 55% of the State's Medicaid beneficiaries, and 34% of the State's Medicare

[14] Data from 2019-2021; includes all LOI hospitals except Staten Island University Hospital
[15] March 2024 NYS PCMH Site Data
[16] "DSRIP Performing Provider Systems (PPS)." www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm.

beneficiaries reside in the selected sub-state region.[17,18,19] The population density in downstate counties contributes to this concentration of beneficiaries in the sub-state region—87.2% of sub-state region residents reside in urban settings, 12.8% reside in suburban settings, and none reside in rural settings.[20] Additionally, 45% of NYS' total health care spend across all payers is concentrated in this sub-state region. Within the sub-state region, public payers likely to participate in the AHEAD Model (Medicaid, Medicare Fee-for-Service (FFS), and the New York State Health Insurance Program (NYSHIP)) cover 72% of healthcare spending, positioning the State to effectively meet accountability targets.[21,22]

Diverse service population

The sub-state region is more racially and ethnically diverse than NYS at large and is representative in terms of age and sex (see *Table 2).*

Table 2. New York State's sub-state region is more diverse than NYS at large[20]

Demographic	Sub-state region	New York State
Age: 18+	79%	80%
Age: 65+	17%	18%
Sex: Female	52%	51%
Sex: Male	48%	49%
Race/ethnicity: White/Non-Hispanic	38%	65%

[17] County Enrollment. https://www.health.ny.gov/health_care/medicaid/enrollment/docs/by_resident_co/2022/2022-12-01.pdf
[18] Bureau, US Census. "New York State Population Topped 20 Million in 2020." Census.gov, 25 Aug. 2021, https://www.census.gov/library/stories/state-by-state/new-york-population-change-between-census-decade.html
[19] CMS Monthly Medicare Enrollment Data, April 2024: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment
[20] Bureau, US Census. "New York State Population Topped 20 Million in 2020." Census.gov, 25 Aug. 2021, https://www.census.gov/library/stories/state-by-state/new-york-population-change-between-census-decade.html
[21]Centers for Medicare & Medicaid Services. "NHE Fact Sheet | CMS." Www.cms.gov, 6 Sept. 2023, www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.; Interstudy for county-level lives by payer, used NHE Table 21 for average spend per member by payer (Medicaid, Medicare, Commercial).
[22] "New York State Health Insurance Program – Empire Plan Members with Dual Family Coverage (Follow-Up) | Office of the New York State Comptroller." Www.osc.ny.gov, www.osc.ny.gov/state-agencies/audits/2022/09/26/new-york-state-health-insurance-program-empire-plan-members-dual-family-coverage-follow. Accessed 18 July 2024.

Race/ethnicity: Black/Non-Hispanic	33%	17%
Race/ethnicity: Asian/Non-Hispanic	21%	12%
Race/ethnicity: 2+ race/ethnicities/Non-Hispanic	5%	4%
Race/ethnicity: Hispanic and/or Latino	30%	20%

Prevalence of health disparities and risk factors

Each county within the sub-state region has a medium to high Social Vulnerability Index (SVI) (0.69-1), with all five counties having an SVI score higher than the overall state SVI score (0.66).[23] The sub-state region experiences a higher rate of quality of life, health behavior, and social and economic risk factors compared to New York State and the United States at large. Specifically, the sub-state region has a higher prevalence of chronic illnesses such as diabetes and HIV. In addition, the sub-state region experiences a shortage of available primary care physicians and mental health providers, and a higher rate of preventable hospital stays (see *Table 3*).[24]

Table 3. NYS sub-state region experiences high prevalence of risk factors[24]

Category	Risk factors for poor health outcomes	Sub-state region	New York State	United States
Health outcomes	**Poor or fair health**	17%	14%	14%
	Diabetes prevalence	12%	10%	10%
	HIV prevalence (# of age 13+ with diagnosis per 100,000 population)	1,137	737	382
Health behaviors	**Food insecurity** (% population lacking adequate access to food)	13%	11%	10%
	Primary care physicians (population per provider)	1,515	1,240	1,330

[23] Agency for Toxic Substances and Disease Registry. "CDC/ATSDR Social Vulnerability Index (SVI) | Place and Health | ATSDR." Atsdrdev.cdc.gov, 3 Nov. 2022, www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html.; State SVI score is population-weighted average of all NYS county SVI scores

[24] County Health Rankings 2024 Measures. https://www.countyhealthrankings.org/health-data/county-health-rankings-measures

	Mental health providers (population per provider)	390	280	320
	Preventable hospital stays (stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees)	2,915	2,641	2,681
	Mammography screening (% of 65-74 Medicare enrollees without annual screenings)	63%	57%	57%
Social and economic factors	**Unemployment**	6%	4%	4%
	Children in poverty (% under 18 in poverty)	23%	19%	16%
	Children in single-parent households (% children in single-parent households	30%	26%	25%

Addressable outmigration patterns[25,26]

For Medicare FFS residents in the sub-state region, more than half (52%) of spend is concentrated within the sub-state region (with 48% spend concentrated outside of the sub-state region)—meeting the AHEAD Model's TCOC regional spend requirement. Of the total 48% outmigration spend, 55% is accrued in Manhattan and 22% in Nassau, with the remaining 23% dispersed among other counties. Of total Medicare FFS outmigration, 60% is for non-emergent care, including administered medications and immunizations (11%), referrals to cardiology (5%), clinical laboratory services (5%), and durable medical equipment and supplies (4%).

Comparatively, a larger proportion (72%) of Medicaid resident beneficiary FFS spend is concentrated within the sub-state region (28% of spend is concentrated outside of the sub-state region). Of the 28% outmigration spend, 63% of spend is accrued in Manhattan and 13% in Nassau, with the remaining 24% dispersed among other counties. Of total Medicaid FFS

[25] "Limited Data Set (LDS) Files 2022 | CMS." Www.cms.gov, www.cms.gov/data-research/files-for-order/limited-data-set-lds-files.
[26] "Virtual Research Data Center Files 2021 | CMS." https://resdac.org/cms-virtual-research-data-center-vrdc

outmigration, 57% is for non-emergent care, including referrals to internal medicine (42%), psychiatry and neurology (8%), other specialists (6%), and family medicine (4%).

Support from sub-state region entities

Sub-state region hospitals with interest in AHEAD participation comprise 66% of hospital net patient revenue (NPR) in the region for all payers. The State has obtained an LOI to participate in AHEAD from 13 hospitals. These hospitals account for 40% of the hospital NPR in the sub-state region. An additional 11 sub-state region hospitals have expressed preliminary interest in AHEAD, comprising the remaining 26% of hospital NPR in the sub-state region.[27]

The State has also obtained a Letter of Support (LOS) from hospital, health care, and primary care associations including: Greater New York Hospital Association (GNYHA), a hospital advocacy organization, Healthcare Association of New York State (HANYS), a health care advocacy and education organization, Primary Care Development Corporation (PCDC), a primary care practice advocacy organization, and Community Health Care Association of New York State (CHCANYS), a community health center advocacy organization. See *Section VI. Hospital Recruitment Plan and Section IX. Primary Care Practice Recruitment Plan* for additional detail on the organizations submitting an LOS.

III. Sub-state accountability targets

Measurement plan for TCOC and primary care spending for all payers

The Office of Health Insurance Programs (OHIP) will be responsible for tracking and reporting TCOC and primary care investment across all payers.

Data collection mechanism for TCOC and primary care spending

[27] 2022 Hospital Institutional Cost Reports (not including Medicaid Supplemental Payments); Facility spend calculated using inpatient and outpatient revenue (excluding supplemental payments for non-service based reimbursements)

OHIP will leverage data capture and reporting capabilities within the Medicaid Enterprise System and obtain all-payer TCOC and primary care spending data from New York State's All-Payer Database, NYS APCD. The NYS all-payer claims database (APCD) compiles Medicaid, Medicare FFS, Medicare Advantage, state health plans, and commercial health plan enrollment data, claims and encounter data, provider data, and hospital discharge data. See *Table 4* for a breakdown of data sources that feed into NYS APCD. The NYS APCD is currently leveraged to support Department of Health research, Medicaid policy and program development such as network adequacy and market penetration. The state is continuing to strengthen the APCD architecture and will utilize the AHEAD cooperative funding to meet model requirements. See *the Budget Narrative* for supporting details.

Table 4. NYS APCD compiles claims and non-claims data across payers

Data Source	Stakeholder	Data Captured	Data availability
Medicaid Managed Care and FFS	Medicaid	Claims data	2014 to present
Medicare FFS	Medicare	Claims data	2014 to 2021
Medicare Advantage	Medicare	Claims data	2018 to present
Fully insured plans	Commercial health plan	Claims data	2018 to present
Self-insured ERISA plans	Commercial health plan	Claims data (though limited given that reporting is voluntary)	2018 to present
Other state health plans (e.g., Qualified Health Plan, Essential Plan, and Child Health Plus)	Other public health plan	Claims data	Essential plan: 2016 to present All other plans: 2014 to present
Statewide Planning and Research Cooperative System (SPARCS)	Provider	Hospital discharge data including patient-level detail (patient characteristics, diagnoses and treatment, services, charges for	Within 60 days from the end of the month of a patient's discharge

		inpatient hospital stay, and outpatient visits)	
Provider Network Data System (PNDS)	Provider	Non-claims data on provider networks including physicians, hospitals, labs, and home health agencies	Can be submitted at any time, but must be submitted at least quarterly

Policy levers to mandate commercial payer reporting for TCOC and primary care spend

In 2011, NYS passed Public Health Law § 2816, authorizing the creation of the NYS APCD to aggregate and distribute all health care services data. Public Health Law § 2816 allows NYS to compel all commercial payers participating in the NYS APCD (except self-insured ERISA plans) to report data on a timely basis. Should these commercial payers fail to comply with reporting requirements, NYS has the authority to implement financial penalties (e.g., fines).

Gaps and challenges in TCOC and primary care reporting

NYS is actively pursuing mitigation strategies to address potential barriers to obtaining comprehensive and up-to-date data from several payer sources (see *Table 5*).

Table 5. NYS will address NYS APCD data gaps with several mitigation strategies

Data Source	Challenge	Potential Mitigation

Medicare FFS	DOH receives Medicare FFS data with a lag because the data is received through a state research data entity use agreement.	DOH is exploring qualification as a Medicare FFS data recipient to obtain up-to-date data. NYS may utilize TCOC reports that CMMI is likely to produce for both the State and participant hospitals. NYS may also request additional reports from CMMI to supplement calculations for AHEAD.
Fully-insured, Commercial plans	Not all commercial payers report claims data. NYS will follow-up and potentially use fines to incentivize compliance.	NYS can work with commercial payers to obtain data and potentially augment with structured survey data.
Self-insured, ERISA plans	Because of the 2016 U.S. Supreme Court ruling, *Gobielle v. Liberty Mutual Insurance Co.,*[28] DOH lacks the authority to mandate reporting from ERISA plans. Any data received from ERISA is provided by the plan on a voluntary basis.	NYS plans to encourage voluntary participation from self-insured ERISA plans and augment with survey data. National surveys may have additional data points.
New York State Health Insurance Plan (NYSHIP)	DOH lacks the authority to mandate reporting from NYSHIP.	DOH plans to engage NYSHIP for support in providing necessary data.
Non-claims-based data	DOH lacks visibility into non-claims-based data needed to set comprehensive TCOC targets (e.g., incentive, infrastructure, and risk-based payments).	DOH will coordinate with payers to request non-claims data (supplemental data elements that go beyond traditionally reported claims data). DOH is also exploring the use of National Association of Health Data Organizations (NAHDO) files to capture non-claims-based payment data.

The State has a robust process for data onboarding and monitoring select aspects of data reporting, including data standardization across payers, data accuracy, timely reporting, and filtering for primary care spend. NYS currently provides all reporting entities with data fidelity

[28] "Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016)." Justia Law, supreme.justia.com/cases/federal/us/577/312/. Accessed 26 June 2024.

education material and standardized data reporting templates. NYS will ensure sufficient time for the identification of deficiencies in initial submission, corrections from reporting entities, and final resubmission. The State will also require MCOs to amend contracts to reflect reporting requirements. The State will address gaps and challenges during the pre-implementation period to ensure it meets CMS' deadline for finalizing targets by October 2027 (90 days prior to Performance Year 2 (PY2).

Memorialization plan for TCOC and primary care investment targets and regulatory and policy levers for increasing primary care spending and for enforcement of TCOC growth targets

The annual New York budget process, which engages both the Executive Chamber and the State Legislature, routinely addresses challenges around TCOC and Medicaid spending including primary care investments. The State intends to use legislative action and administrative authority to memorialize a plan for determining TCOC and primary care investment targets. This will include a process to determine the all-payer TCOC growth target and the process for setting the all-payer primary care investment targets by October 2026 (90 days before the start of PY1) for the sub-state region. It will also appoint one state agency or entity responsible for coordinating state reporting of all-payer TCOC and all-payer primary care investment. The actions will also include methods to increase the relative share of Medicaid and commercial primary care spending and accountability mechanisms for evaluating the TCOC cost growth target. The State will set targets to continue through AHEAD's implementation period (January 2027 through December 2034). To ensure the sustainability of program requirements throughout the implementation period, the legislative action will include a clause authorizing OHIP to modify policies over time or create additional regulations as needed. The process to

enact this authorizing legislation will take several months and will likely be part of New York State's annual budget process. This estimate includes the time required for legislation drafting, introduction as part of the Governor's Executive Budget (negotiated with the NYS Legislature), and passage via the Enacted Budget. To meet the AHEAD Model implementation deadline of January 2027, OHIP will initiate drafting the legislation by June 2025 to submit as part of the Governor's Executive Budget in January 2026, which is expected to be finalized in the Enacted State Budget by April 2026. This meets the CMS requirement to memorialize targets (or memorialize the process to create targets) by October 2026 (90 days prior to PY1 in January 2027).

Anticipated challenges for meeting targets

To mitigate any potential reluctance to participate in AHEAD among commercial payers, NYS plans to engage and educate commercial payers, starting with NYSHIP, a health insurance program established for public employees in the State and administered by the Department of Civil Service (DCS) , and EP, which has over 780,000 sub-region enrollees respectively, for early support and buy-in. The State may consider technical assistance to mitigate other anticipated challenges, including delays in data sharing and reporting, difficulty achieving return on investment in primary care and prevention programs, and overall health care inflation. The State will also plan to address additional potential policy barriers, including memorializing and enforcing targets and engaging a diverse provider and payer market.

IV. Hospital recruitment plan

Summary of interest

Summary of hospital interest

Since 1997, NYS has engaged with hospitals to improve population health for New Yorkers through an 1115 Waiver. Most recently, NYS solicited interest and obtained an LOI from 12 safety net hospitals (SNH) in the sub-state region to participate in AHEAD through the State's most recent 1115 Waiver Amendment, New York Health Equity Reform (NYHER). See *Appendix: Hospital LOIs* and *Table 6* for a full list of hospitals submitting an LOI. Notably, three hospitals—Maimonides Medical Center, Montefiore Medical Center, and St. Barnabas Hospital—have previous experience as DSRIP PPS.

Safety net hospitals generally have a greater share of low-income, ethnically diverse patients with high patient-related access barriers to care (e.g., uninsured) compared to non-SNHs. Given these disparities, the participation of these hospitals in AHEAD may have a significant impact on the Model's goal to improve health equity.

The 13 hospitals submitting an LOI represent Bronx, Kings, Queens, Richmond, and Westchester counties. These hospitals cover nearly 40% of the hospital NPR in the sub-state region across all lines of business, 38% of Medicare FFS hospital NPR, 42% of Medicaid hospital NPR, and 13% of TCOC spend.[29,30] See *Table 6* below for a detailed breakdown of each hospital and its portion of sub-state region hospital net patient revenue.

Potential future expansion to the 11 other hospitals interested in AHEAD would cover an additional 26% of hospital NPR in the sub-state region across all lines of business, 23% of Medicare FFS hospital NPR, 40% of Medicaid hospital NPR, and approximately 8% of TCOC

[29]2022 Hospital Institutional Cost Reports (not including Medicaid Supplemental Payments); To calculate TCOC in region, Interstudy lives by LOB (Medicaid, Medicare, Commercial) were respectively multiplied into National Health Expenditure Table 21 average expenditures per member by LOB

[30] 2022 Hospital Institutional Cost Reports (not including Medicaid Supplemental Payments); Hospital NPR percent defined as percent of total in-patient and out-patient spend in sub-state region by each hospital

spend in the sub-state region.[31,32] Dan Tsai, Deputy Administrator and Director of Center for Medicaid and CHIP Services, and other CMS leadership conducted a hospital site visit with NYS to assess the viability of expanding hospital global budget implementation to additional hospitals. To supplement potential expansion efforts, the State will conduct recruitment activities such as educational sessions, one-on-one discussions, and financial modeling. See *Hospital recruitment timeline* subsection for additional information on these activities.

Table 6. Hospitals expressing formal interest in AHEAD comprise 40% of hospital net patient revenue in the sub-state region.[32]

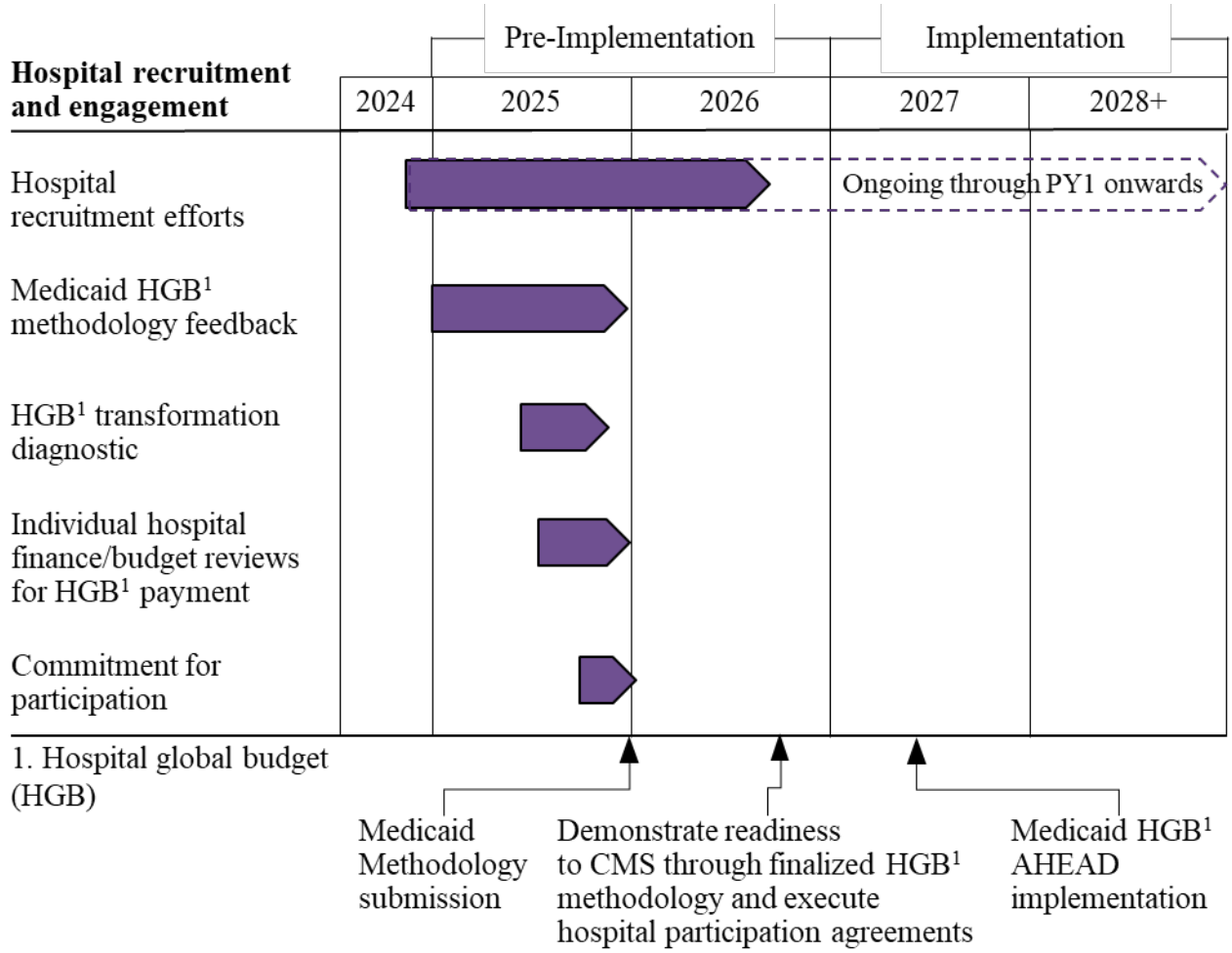
County	Hospital submitting an LOI	Hospital NPR % in sub-state region
Kings	Maimonides Medical Center	5%
Kings	Brookdale Hospital Medical Center	3%
Kings	Brooklyn Hospital Center	2%
Kings	Wyckoff Heights Medical Center	1%
Queens	Jamaica Hospital Medical Center	2%
Queens	Flushing Hospital Medical Center	1%
Queens	St. John's Episcopal Hospital	1%
Westchester	St. John's Riverside Hospital	1%
Westchester	St. Joseph's Hospital – Yonkers	1%
Westchester	Montefiore Mount Vernon Hospital	<1%
Bronx	Montefiore Medical Center	13%
Bronx	St. Barnabas Hospital (SBH Health System)	2%
Richmond	Staten Island University Hospital	8%
Total	N/A	40%

[31] 2022 Hospital Institutional Cost Reports (not including Medicaid Supplemental Payments); To calculate TCOC in region, Interstudy lives by LOB (Medicaid, Medicare, Commercial) were respectively multiplied into National Health Expenditure Table 21 average expenditures per member by LOB

[32] 2022 Hospital Institutional Cost Reports (not including Medicaid Supplemental Payments); Hospital NPR percent defined as percent of total in-patient and out-patient spend in sub-state region by each hospital

Hospital recruitment timeline

Chart 7. The State will recruit and engage hospitals through the start of the implementation period.



Throughout the pre-implementation period, the State will support hospital recruitment, obtain feedback, and support readiness on global budget methodology to prepare for AHEAD implementation.

- The State will continue recruitment activities from Q3 2024 through the end of Q3 2026 through engagement of hospitals and hospital associations. Activities include educating hospitals on AHEAD goals and benefits, sharing relevant updates, and soliciting questions and feedback through webinars, fact sheets, group meetings, and one-on-one sessions. Throughout the initial pre-implementation period recruitment cycle, the State will track hospital participation status (i.e., "participating," "continue engaging," "no further engagement," and "new/interested"). The State will use lessons learned from the first recruitment cycle to further engage and recruit applicable hospitals in PY2 and PY3 on a condensed timeline.
- Starting Q1 2025, the State will hold group meetings and one-on-one discussions for CMS and hospitals to provide feedback on Medicaid and Medicare global budget methodology to prepare for CMS methodology submission by the end of 2025.
- Starting Q2 2025, the State will initiate group and one-on-one engagement with hospitals to understand hospital global budget readiness. The State will utilize these conversations to enable hospital global budget transformation diagnostics (a form of technical assistance). This diagnostic will support hospitals to identify gaps in capabilities required to implement AHEAD.
- Starting Q3 2025, the State will work with hospitals to understand the potential financial impacts of transitioning to a Medicaid hospital global budget methodology and support with modifications to existing contract agreements with payors.

- These activities will support hospital readiness for a Medicaid hospital global budget and ensure commitment to AHEAD hospital participation milestone by end of 2026 (at least 90 days prior to PY1).
- In addition to pre-implementation efforts to prepare hospitals for the global budget transformation, the State will utilize the Model Governance structure to incorporate hospital input on quality, equity, and all-payer topics (e.g., statewide population health and quality measures, equity targets, and Health Equity Plans) starting Q3 2025. This aligns with AHEAD's goal to include clinicians, especially those representing underserved communities, in plans to drive accountability toward Model outcomes.

Policies to incentivize participation

The State will rely on voluntary hospital participation in the AHEAD Model. With 13 hospitals submitting an LOI, NYS expects to meet AHEAD milestones and therefore does not anticipate using regulatory levers to mandate hospital participation. The State will monitor the proportion of Medicare FFS NPR under hospital global budget across performance years to inform hospital recruitment contingency planning as necessary.

The State acknowledges that hospitals may face barriers to effectively transitioning to and successfully adopting a hospital global budget model. To mitigate these challenges, the State will offer targeted financial incentives under NYHER, which authorizes $2.2 billion over 3.25 years ($550 million annually) to transform financially distressed hospitals and promote value-based care.[33] These incentives will support essential infrastructure upgrades, training sessions, ongoing technical assistance, and sustained participation.

[33] Department of Health & Human Services, Centers for Medicare & Medicaid Services. https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_cms_ltr.pdf

Every two weeks, OHIP's Division of Finance and Rate Setting (DFRS) supports hospitals with reviewing financial statements, creating annual financial projections, assessing monthly cash flow, and benchmarking against expected trends. In addition, as shown in *Chart 7* above, the State will explore the use of a diagnostic to assess hospital readiness for a hospital global budget and support hospitals in prioritizing transformation areas. *Table 8* includes a broad list of clinical and functional capabilities that the State may evaluate as part of a diagnostic.

Table 8. Potential clinical and functional capabilities required for AHEAD implementation

Category	Capability	Examples of capability-building activities
Clinical care capabilities (pre-acute, acute, and post-acute care)	Evidence-based medicine and care pathways	Implementing health improvement initiatives (e.g., behavioral health initiatives)
	Access, referrals, and care transitions	Enhancing patient care coordination and managing service outmigration (e.g., community needs assessments and engagement)
	Care team and practice management	Optimizing healthcare workforce management
	Coding and documentation	Ensuring comprehensive medical record-keeping
Functional capabilities	Strategic planning	Developing long-term strategic initiatives (e.g., service line optimization)
	Finance and contracting	Overseeing financial operations and agreements (e.g., contract language for HGB payments)
	Operations transformation	Improving operational efficiency
	Data, analytics, and IT	Developing robust data and analytics systems, and IT infrastructure (e.g., health related social needs (HRSN) data collection and root cause analysis)
	Talent, organization, and change management	Fostering staff development and organizational growth

Recruitment goals and challenges

The State will prioritize the recruitment of interested safety net hospitals that represent the largest portions of in-sub-state region TCOC. By participating in AHEAD, these safety net

hospitals may significantly impact the State's population health outcomes and improve their own financial stability. We look forward to CMS support in achieving some key programmatic flexibility to further enhance participation.

The State recognizes that some hospitals may vary in transformation capabilities required to succeed in a hospital global budget. Some hospitals may be hesitant to take on financial risks, may be too resource constrained to implement a model, or may have different priorities that do not align with the AHEAD Model. The State plans to leverage stakeholder and association relationships to support hospitals in transformation initiatives.

With support from 13 hospitals submitting an LOI and 11 additional hospitals expressing preliminary interest in AHEAD, the State does not anticipate needing a contingency plan to meet AHEAD recruitment milestones.

V. Hospital global budget methodology

Rate setting authority for hospital global budget

The State plans to use the CMS-designated methodology for the Medicare FFS hospital global budget model.

The State approximates that 75% of its Medicaid population is covered by MCO plans and 25% is covered by the FFS plan.[34] To modify the FFS plan to include hospital global budget payments, NYS plans to work to secure the necessary approvals of an 1115 demonstration waiver for inpatient and outpatient services, as well as pursue statutory changes to FFS supplemental payments under the Disproportionate Share Hospital (DSH) program and the Upper Payment Limit (UPL) demonstration (if needed). To direct MCOs to make hospital global

[34] "Healthcare Interstudy 2023 | HealthLeaders." www.healthleadersmedia.com/intelligence-reports www.health.ny.gov/health_care/managed_care/reports/docs/final_report_mco_services.pdf, https://doi.org/10.1016/j.rcl.2024.03.001.

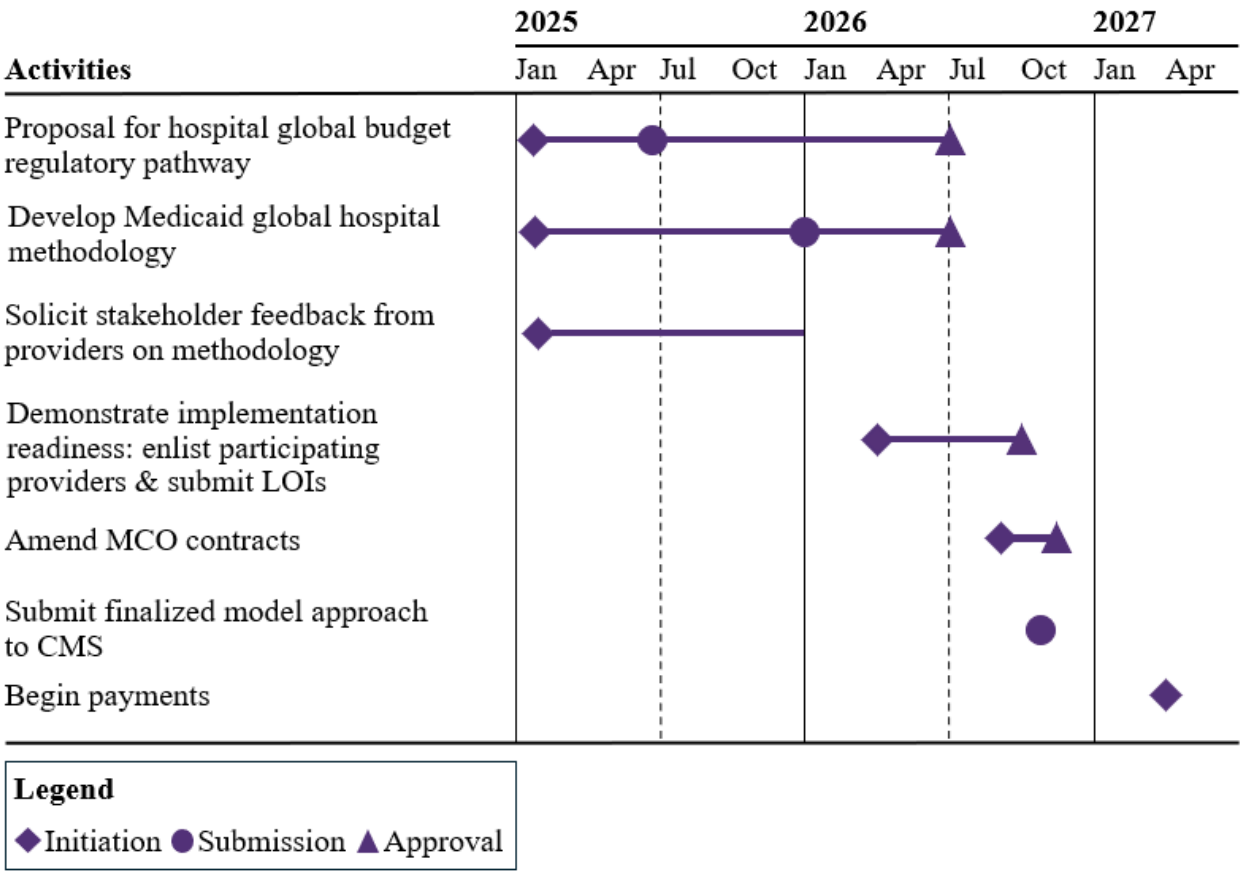
budget payments, NYS anticipates utilizing State Directed Payment (SDP) in addition to modifications of MCO contracts. NYS will collaborate with CMS to determine the appropriate regulatory pathways to guarantee permanent budget and rate setting authority. OHIP will plan to submit any needed SPAs or other identified pathways before sending all authority documentation to CMS for approval by July 2025.

Capacity to develop and implement Medicaid hospital global budget methodology

Implementation Timeline

NYS will begin Medicaid pre-implementation activities in January 2025 with the goal to begin Medicaid Hospital Global Budget payments on or before April 2027 (see *Chart 9)*. This approach allows for alignment with the State's fiscal year calendar and streamlines non-budget-related, pre-implementation activities with Medicare implementation (e.g., data gathering, performance transparency and reporting, and stakeholder engagement and recruitment).

Chart 9. NYS will collaborate with stakeholders to prepare for April 2027 hospital global budget implementation



Stakeholder engagement

To ensure that the State's Medicaid methodology reflects stakeholder voices, NYS will solicit feedback from providers on key methodology design decisions such as services to be included, populations to be included and excluded, and hospital quality metrics. During this period, NYS will also engage CMS on key methodology decisions. NYS will also offer guidance to and solicit feedback from MCOs to adapt their operating models to the new global budget methodology.

NYS will conduct its provider outreach efforts through collaboration with hospitals and associations throughout the pre-implementation period. To date, NYS has conducted information sessions with 13 LOI hospitals on AHEAD objectives and implementation requirements. The

State will continue this work with AHEAD education and recruitment and support hospitals with AHEAD transformation activities. See *Section VI. Hospital recruitment plan*, for additional information on the technical assistance that NYS will provide to hospitals.

VI. Primary care transformation and model

Current primary care transformation initiatives under Medicaid Primary Care Alternative Payment Model (APM)

The State operates the largest PCMH program in the country—20% of all PCMH practices and 16% of all PCMH providers in the country operate within NYS.[35] The NYS PCMH program is a qualified Medicaid Primary Care APM aimed at improving patient experience and accessibility to high quality primary care. To achieve NYS PCMH recognition, primary care practices and providers must meet all 40 NQCA-core criteria, 11 NYS-specific criteria (with elective credit), and an additional 8 to 10 elective criteria credits of their choosing.[36] Criteria span six concepts, including team-based care and practice organization, care management and support, knowing and managing patients, care coordination and care transitions, patient-centered access and continuity, and performance measurement and quality improvement.

Achievement and sustained deployment of these criteria allows practices and providers to provide their patients with a more comprehensive approach to primary care through increased investments in behavioral health (e.g., screenings and referrals to behavioral health care management to coordinate needs), care management for specialty and HRSN (e.g., referrals to social services), and health information technology capabilities for population health

[35] March 2024 NYS PCMH Site Data
[36] New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program. https://www.health.ny.gov/technology/nys_pcmh/docs/pcmh_release_requirements.pdf.

management activities (e.g., reporting patient demography to inform solutions to address needs of diverse population).

These NYS PCMH-recognized practices receive enhanced reimbursement for services through the New York Statewide Medicaid PCMH Incentive Program in the form of an MMC Per Member Per Month (PMPM) payment and a Medicaid FFS add-on for professional and institutional claims.

Through these efforts, the NYS PCMH program has achieved significant statewide primary care practice penetration: 66% of MMC beneficiaries are assigned to NYS PCMH-recognized primary care providers.[37] Family medicine, internal medicine, and pediatric practices all participate in the program.[38] In addition, the NYS PCMH program has provided an avenue for smaller practices to obtain additional revenue. Single-provider practices comprise the largest portion of PCMH practices, representing 30% of NYS PCMHs.[38]

Alignment of current Medicaid primary care initiatives with Primary Care AHEAD

The State plans to align Primary Care AHEAD with NYS PCMH. NYS PCMH's core criteria meet Primary Care AHEAD requirements, including the integration of behavioral health as a function of primary care, enhanced care management and specialty coordination, and addressing HRSN. To be eligible for Primary Care AHEAD, primary care practices must: a) be New York State PCMH-recognized and can be either independent or if affiliated with a hospital that hospital must be participating in AHEAD; and b) attest to having a workflow to refer patients to the Social Care Network (SCN) program, established under the NYHER, for HRSN

[37] March 2024 NYS PCMH Site Data
[38] New York State Patient Centered Medical Homes Quarterly Report. 2023. https://www.health.ny.gov/technology/nys_pcmh/docs/pcmh_quarterly_report_june_2023.pdf

screening and resource navigation (see *Section XI. Health equity approach* for additional information on the SCN).

The State is leveraging the Medicaid PCMH model for engagement across the delivery system as it has also served as a model for positive engagement through the Making Care Primary (MCP) model and commercial payer outreach initiated with MCP. We anticipate alignment of quality measures across models further streamlining provider engagement. As part of a broader value-based payment strategy, New York is evaluating the potential impacts, pros, and cons of sub capitated payment in primary care.

Tools to increase Medicaid primary care investment

To increase statewide primary care investment, NYS will establish primary care spending targets for all-payers, including Medicaid. These targets will be measured as a proportion of TCOC spend.

The State has already successfully increased Medicaid FFS rates for primary care. In 2021, NYS benchmarked the Medicaid FFS physician fee schedule to 60% of Medicare rates for non-facility services. This benchmark increased over two years, resulting in 80% of Medicare rates in April 2023.[39] In 2024, NYS intends to offer an additional $2-4 PMPM to NY PCMH-recognized primary care providers who develop a workflow to refer patients to the SCN on top of the $6 PMPM currently paid to primary care providers that are NY PCMH recognized.

Policy tools to increase primary care access[40]

[39] New York State Medicaid Update – August 2023 Volume 39 -Number 13https://www.health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm

[40] 1115 Medicaid Redesign Team Waiver Webinar: NYHER https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2024-02-16_nyher_overview_slides

The State will improve primary care access by increasing its a) provider workforce, b) Medicaid service coverage, c) primary care appointment availability, and d) Medicaid reimbursement rates. These primary care investments will benefit the sub-state region, a socially vulnerable population with relatively poorer health outcomes across a subset of measures (e.g., diabetes, preventable hospitalizations) whose access barriers and health disparities can be mitigated through expanded primary care incentives, services, and availability. NYHER authorized NYS to invest up to $694 million in primary care workforce recruitment and retention. Approximately $50 million of this funding will be used to incentivize existing primary care physicians and nurse practitioners to further serve Medicaid beneficiaries. If these providers make a four-year commitment to serve a Medicaid and/or uninsured patient panel of at least 30% (on average), NYS will repay their student loans. NYS will use the remaining approximately $650 million to develop a Career Pathway Trainings (CPT) program to strengthen the Medicaid provider pipeline. Individuals interested in pursuing a career in health care as a nurse, physician assistant, social worker, counselor, community health worker, or any other frontline public health worker will have their education and training sponsored with the resources made available by NYHER. The sponsorship is contingent upon a three-year commitment to serve a patient panel comprised of at least 30% Medicaid and/or uninsured patients (on average).

NYS' Enacted Budget FY 2024 authorizes $53.7 million in FY 2024 to expand Medicaid coverage of preventative health services. This amount will grow to $104.1 million in FY 2025. These preventative services include supportive housing, Adverse Childhood Experiences (ACE) screening, nutritionist services, therapy coverage, dental care, children's vaccine administration, prenatal screenings, HRSN screening, and doula service coverage. The Enacted Budget also invests $46 million in FY 2024, growing to $104.4 million to support evidence-based

interventions to improve access to primary care to reduce preventable hospitalizations and ED visits. A pending 1115 waiver amendment will also allow the State to provide continuous eligibility for children ages 0-6 under Medicaid and Child Health Plus, which is expected to take effect in January 2025.

Accessibility is a core tenet of the PCMH model, which aligns with Primary Care AHEAD eligibility criteria. PCMH requires primary care practices and providers to provide enhanced, in-person hours, around-the-clock telephone or electronic access to a care team member, and open scheduling hours. MCOs also increasingly provide their own telehealth services for patients.

Given current Medicaid access gaps, NYS believes its benchmarking of Medicaid rates to 80% of Medicare FFS rates and increased Medicaid reimbursement rates for providers serving individuals with disabilities and complex needs will also encourage practices to increase their Medicaid patient panel.[41]

Plans for state Medicaid Primary Care APM

NYS plans to create consistency in the State's overall primary care strategy by aligning the NYS PCMH program with Making Care Primary and integrating performance-based, prospective payments. NYS intends to transition the $2-4 enhanced PMPM into a performance-based bonus payment and eventually into a VBP arrangement. NYS will explore this long-term transformation strategy via an SDP or through partnerships with MCOs.

FQHC & Rural Health Clinic (RHC) involvement in existing Medicaid Primary Care APM

[41] Enhanced Medicaid Reimbursement Rates for Primary Care Services., https://www.acponline.org/sites/default/files/documents/advocacy/where_we_stand/assets/v1-enhanced-medicaid-reimbursement-rates.pdf

Many FQHCs and RHC are already participants in NYS' PCMH model and will be eligible to participate in the Medicaid Primary Care APM. Approximately 39% of all FQHCs (886) within New York State are PCMH-recognized; 34% of all FQHCs (412) within the sub-state region are PCMH-recognized.[42] The State is exploring means of technical assistance to help further FQHC PCMH adoption and is building feedback around the key remaining barriers to understand any potential additional levers available to support providers in obtaining certification.

VI. Primary care practice recruitment plan

State experience in Medicaid Primary Care APM

In 2018, NYS developed the NYS PCMH program, a qualified Medicaid Primary Care APM. Within the sub-state region, 3,144 providers and 780 (of approximately 2,500) practices in the sub-state region are PCMH recognized, representing 30% of practices and 64% of MMC beneficiaries in the sub-state region.[43,44]

Summary of primary care practice interest

NYS will invite all NYS PCMH practices in the sub-state region to participate in Primary Care AHEAD, including practices affiliated with hospitals submitting an LOI, independent practices, and FQHCs.

The State will focus the start of its recruitment on NYS PCMH-recognized primary care practices affiliated with hospitals submitting an LOI to ensure strategic alignment across Medicaid hospital global budget and Primary Care AHEAD participation in the Model. These

[42] New York State Office of Health Insurance Programs Data August 2024, HRSA FQHCs and LALs by State. https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs
[43] NYS practice dataset by county July 2024 from Interstudy and Definitive Data
[44] NYS PCMH Practice Data March 2024 for PCMH Medicaid Managed Care (MMC) lives compared against DRG Interstudy from July 2023 for total Medicaid Managed Care Lives in the region

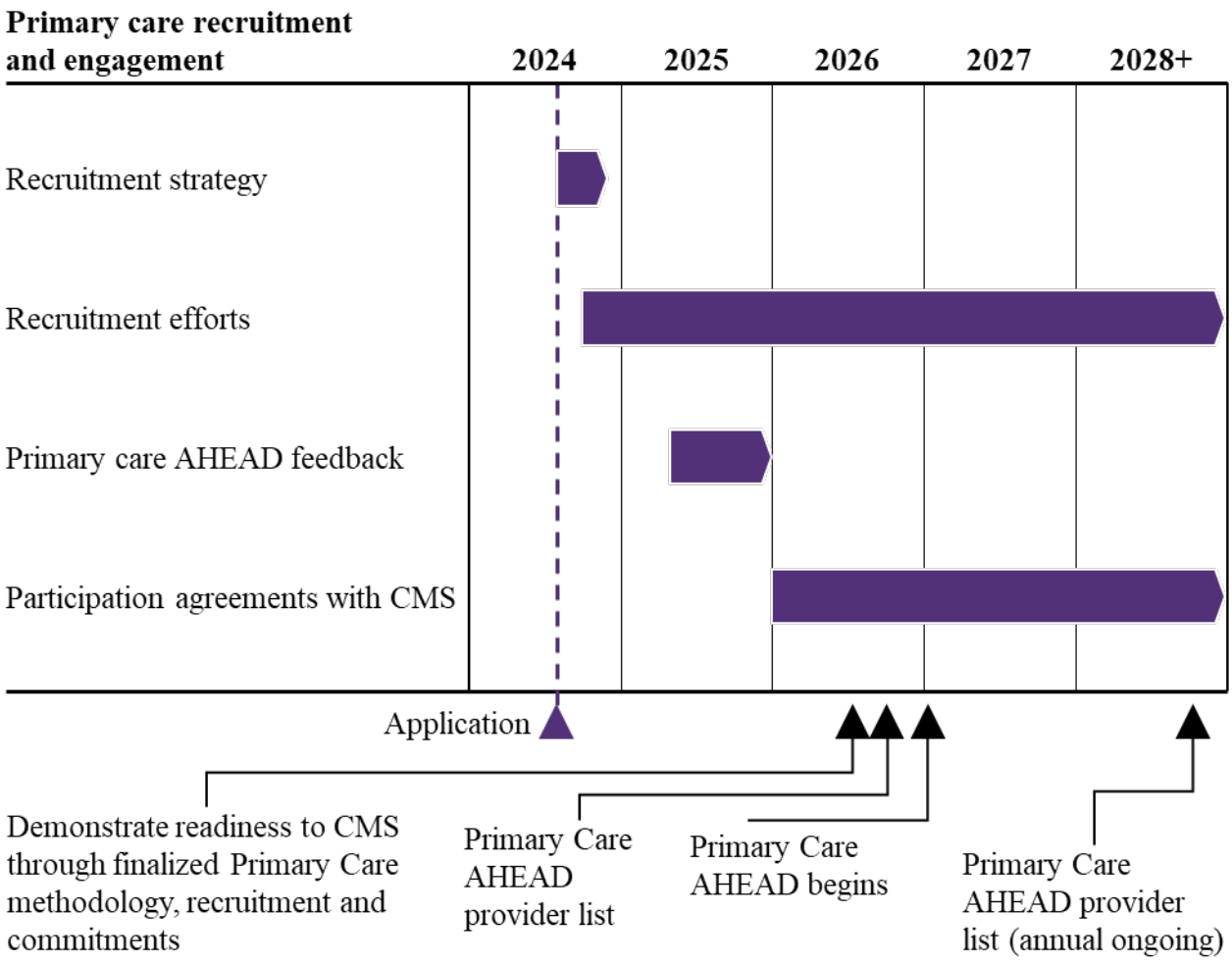
practices (e.g., Montefiore Physicians, Maimonides Medical Center Physicians, Brookdale University Hospital Medical Center Physicians, and St. John's Episcopal Hospital Physicians) comprise 6% of MMC beneficiaries in the sub-state region and 8% of PCMH practices in the sub-state region.[45]

Additional eligible NYS PCMH-recognized practices include independent primary care practices (including FQHCs) that represent 85% of PCMHs in the sub-state region and serve 52% of MMC members in the sub-state region. Independent FQHCs represent 16% of NYS PCMHs in the sub-state region and serve 17% of MMC members in the sub-state region. The State will prioritize FQHCs in the recruitment process due to their large uninsured and Medicaid patient panel.[46] NYS will draw upon expertise of primary care providers, associations and other subject matter experts to craft effective, tailored outreach and education to target this diverse mix of NYS PCMH practices.[47]

Primary care practice recruitment timeline

Chart 10. NYS will plan to recruit primary care practices on an ongoing basis

[45] March 2024 NYS PCMH Site Data for PCMH Medicaid Managed Care (MMC) lives; to calculate in region PCMH MMC member penetration/adoption, NYS-wide OHIP PCMH panel sizes were compared to NYS-wide Interstudy yearly MMC lives and scaled using actual NYS PCMH quarterly MMC member counts. In region PCMH adoption by member is similar to statewide. Refers to PCMH practices affiliated with the 13 LOI hospitals.
[46] There are no PCMH-RHCs in the chosen sub-state region.
[47] March 2024 NYS PCMH Site Data for PCMH Medicaid Managed Care (MMC) beneficiaries; to calculate in region PCMH MMC member penetration/adoption, NYS-wide OHIP PCMH panel sizes were compared to NYS-wide Interstudy yearly MMC lives and scaled using actual NYS PCMH quarterly MMC member counts. In region PCMH adoption by member is similar to statewide. Independent primary care practices include practices not affiliated with the 13 LOI hospitals and exclude FQHCs. Independent FQHCs encompasses FQHC practices not affiliated with any hospitals.



NYS will conduct and support primary care practice recruitment from the pre-implementation period through the implementation period.

- With support from key stakeholders and primary care organizations, NYS will define its recruitment strategy in Q3 2024 and begin implementing its primary care practice recruitment efforts in Q4 2024.
- Starting Q4 2024 and throughout implementation, NYS and its partners will conduct educational webinars, group meetings, and one-on-one meetings with eligible PCMH primary care practices. By employing this multi-modal approach to recruitment, NYS will be able to engage a wide range of primary care practices and cover significant

Primary Care AHEAD content. Webinars will offer regular engagement with primary care practices and detailed information on AHEAD Model goals, benefits, and requirements. NYS and its partners will lead group meetings that serve as interactive forums for discussion and feedback on AHEAD. One-on-one meetings will allow NYS and its partners to provide individualized support for primary care practice-specific inquiries. To further encourage participation in Primary Care AHEAD across this multi-modal approach, NYS will highlight the limited additional requirements necessary for PCMH primary care practices to participate in Primary Care AHEAD and the financial benefit (EPCP) primary care practices will receive for their Medicare FFS population.

- To supplement its educational activities, NYS will create a repository of Primary Care AHEAD collateral, including written materials and educational briefs. The State will also utilize direct email communication, as leveraged for NCQA PCMH recognition correspondences, to further primary care practice engagement, if necessary.
- NYS will solicit feedback received during webinars, group meetings, and one-on-one consultations from primary care practices on Primary Care AHEAD model design, quality metrics, and data collection approaches. The State will collect feedback throughout 2025 to ensure alignment with primary care practice needs. Thereafter, program design requirements will be memorialized in formal participation agreements with CMS detailing responsibilities and commitments of practices and the program. CMS will execute these agreements with primary care practices on an ongoing basis.
- During implementation, NYS will support primary care practices by utilizing CMS technical assistance to meet Primary Care AHEAD data collection and workflow requirements.

Recruitment goals and challenges

NYS will include all NYS PCMH practices in recruitment efforts, starting with practices affiliated with hospitals submitting an AHEAD LOI throughout the performance period. FQHCs will be prioritized in the Primary Care AHEAD recruitment process due to their large uninsured and Medicaid patient panel.[48]

The State recognizes that primary care practices may face potential barriers to participation in Primary Care AHEAD. To be eligible for Primary Care AHEAD, primary care practices must be NYS PCMH-recognized, have an affiliate hospital participating in AHEAD (if applicable), and build a workflow to refer Medicaid patients to their regional SCN (see *Section VI. Vision for primary care transformation* for additional information on NYS PCMH criteria). As of 2024, 70% of primary care practices representing 36% of MMC beneficiaries in the sub-state region are not NYS PCMH-recognized. To be eligible for EPCP payments from CMS, practices must further incorporate five outcomes-based measures for Medicare FFS beneficiaries. Some practices may not have the necessary staff to support practice transformation and reporting requirements. Practices may also be hesitant to participate in AHEAD if they have difficulty assessing its financial and operational implications, understanding overlap with existing or other CMS models of interest (e.g., ACO REACH), or deploying a program that may only benefit a small portion of their patient panel.

To mitigate these potential challenges, NYS will work in partnership with PCDC and CHCANYS to support education and necessary transformation efforts. NYS will explore adding enhanced PCMH PMPMs for advanced care delivery infrastructure development. Additionally,

[48] There are no PCMH-RHCs in the chosen sub-state region.

NYS NYHER investment in primary care workforce recruitment and retention will support increased primary care AHEAD participation among downstate New York providers.

VIII. State data, IT infrastructure, and systems

Current statewide data/health IT infrastructure

Existing data infrastructure plans and governance

New York State has four relevant data systems in its health data infrastructure for AHEAD: a) NYS APCD, b) QARR, c) SPARCS, and d) SHIN-NY. NYS' all-payer database (NYS APCD) captures all-payer enrollment data, benefits data, claims and encounter data, provider data, hospital discharge data, and vital statistics mortality data with plans to integrate non-claims data.[49] Quality Assurance Reporting Requirements (QARR) is NYS DOH's public reporting system that requires health plans to submit NCQA, HEDIS, CMS, and NYS-specific health outcome and process measures.[50] The Statewide Planning and Research Cooperative System (SPARCS) is a hospital reporting system collecting patient-level hospital discharge data with details on patient characteristics, diagnoses and treatments, and pre-adjudicated charges.[50] The Statewide Health Information Network for New York (SHIN-NY), the State's provider health information exchange (HIE), a network of shared electronic, patient clinical records. More than 90% of providers participate in this health information exchange.[51]

NYS DOH oversees or establishes governance committees for these data systems. NYS' Center for Health Data Innovation in the Office of Health Systems Quality and Analytics (OHSQA) manages the NYS APCD. NYS DOH sets strategy and regulations for SHIN-NY and

[49] New York State All-Payer Database Guidance Manual. Nov. 2022, https://nyshc.health.ny.gov/documents/39436/243045/APCD_guidance_manual.pdf.
[50] Data Governance Policy and Procedure Manual for Data Release Statewide Planning and Research Cooperative System, https://www.health.ny.gov/statistics/sparcs/training/docs/sparcs_dgc_manual.pdf 2022.
[51] SHIN-NY Organizational Infrastructure. https://www.health.ny.gov/technology/infrastructure/

relies on New York eHealth Collaborative (NYeC) for administration and input on provider policy and technical recommendations. For the SPARCS system, NYS DOH established the SPARCS Data Governance Committee (DCG) to review identifiable data requests, vote, and make data approval recommendations to the NYS Commissioner of Health.

In recent years, NYS has invested in building a technology infrastructure that allows multiple stakeholders to access high quality data covering patients' full care continuum.[52] NYS built this infrastructure through the MCO-QE project, HIT-Enabled QM roadmap, VBP roadmap, and continued investments by the State's Executive Budget and NYHER. The State has deployed a cloud analytic environment to integrate data from the NYS APCD, SPARCS, vital statistics, and SHIN-NY. It has also implemented cloud-based analytics tools to support analysts' access and use of the data and leveraged the SHIN-NY's Master Person Index to identify individuals across SPARCS, SHIN-NY, and vital statistics. NYS will expand this capability to include NYS APCD data.

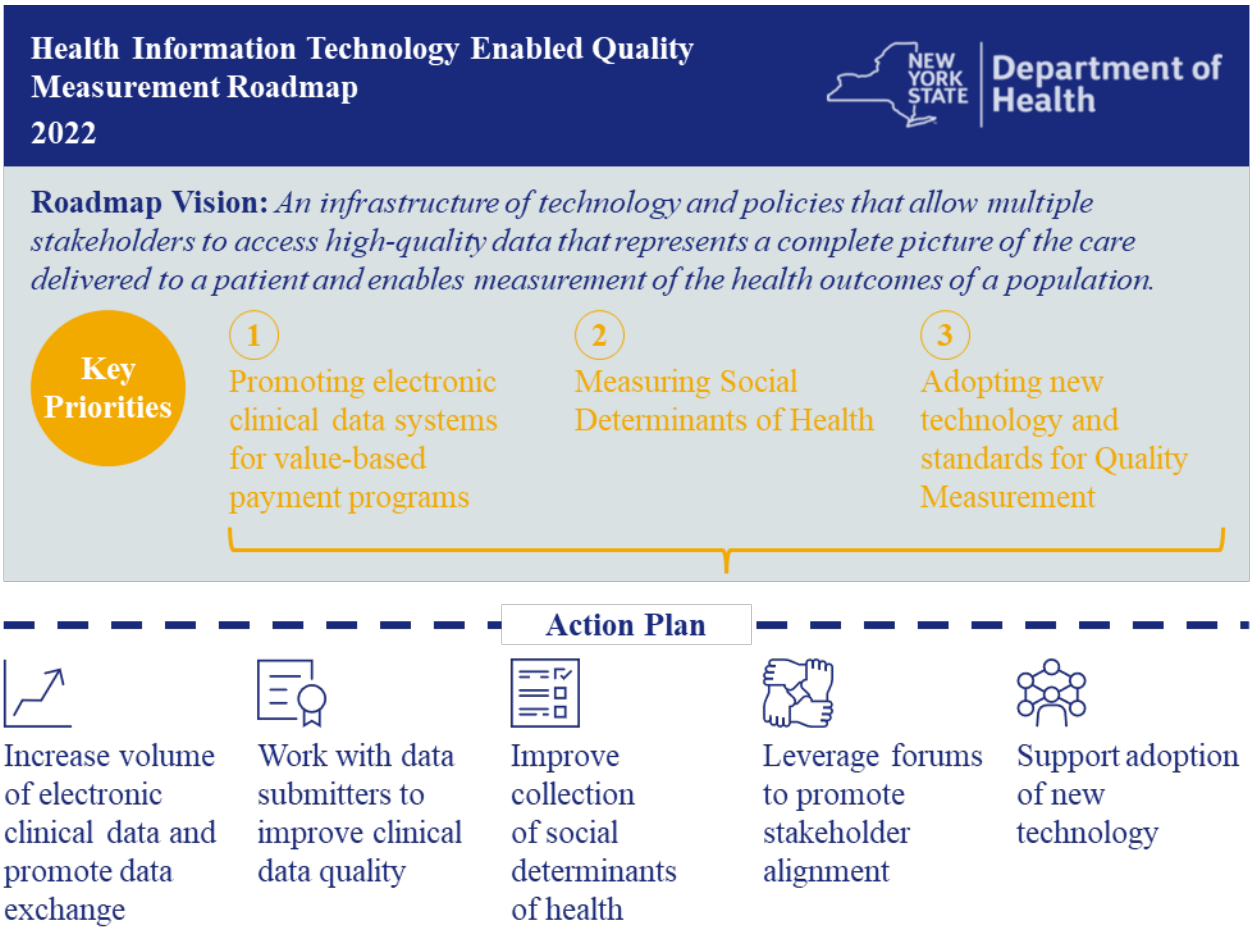
In 2021, NYS initiated the MCO-QE project, focused on building supplemental data exchange connections between MCOs and QEs.[53] This project increased the State's availability of quality, electronic clinical data and increased standards for data exchange.

In June 2021, NYS established the HIT-Enabled QM roadmap, a three-to-five-year health data IT infrastructure action plan.[53] The action plan aimed to better integrate electronic clinical data systems into VBP programs, measure HRSN, and adopt new technology and standards for quality measurements. NYS will achieve these priorities by increasing volume and quality of

[52] Kirkwood, Jim. Health Information Technology- Enabled Quality Measurement Roadmap Prepared For, https://health.ny.gov/technology/qm/docs/2022_roadmap.pdf, 2022.
[53] Data Governance Policy and Procedure Manual for Data Release Statewide Planning and Research Cooperative System, https://www.health.ny.gov/statistics/sparcs/training/docs/sparcs_dgc_manual.pdf 2022.

electronic clinical data, improving collection of HRSN-related data, promoting stakeholder alignment through the Learning Collaborative (a stakeholder working group for health IT), and supporting the adoption of new and emerging technology. The improved collection of HRSN-related data will be supported by NYHER initiatives to gather HRSN data that will flow through the SCN's data and IT platform supported by SHIN-NY. See *Chart 11* below for additional information on the action plan.

Chart 11. NYS' HIT-Enabled QM Roadmap 2022 details opportunities, key priorities, and action plans for NYS' health data infrastructure



NCQA validated all six NYS QEs through its Data Aggregator Validation program. This program assesses aggregated clinical data to support accuracy for data users. The program utilizes standardized data file formats to promote seamless data exchange.[54]

In 2024, NYHER and NYS' Enacted Budget FY 2024 allocated funds to enhance NYS' health data infrastructure. NYHER authorized NYS to invest $500 million into building regional SCNs that will collect, integrate, and enhance SHIN-NY's collection of HRSN and non-claims-based data.[55] Separately, the State's Enacted Budget FY 2024 allocated up to $500 million of the Statewide Health Care Facility Transformation Program's $1 billion budget to enhance NYS' health data infrastructure through provider data infrastructure transformation, cybersecurity tools, and data quality improvements.[56]

Staff capacity, capabilities, and experience with VBP and quality reporting

Within the NYS DOH, OHIP, and the Office of Health Services Quality and Analytics (OHSQA) will support data analysis, reporting, and HIT and HIE infrastructure maintenance.

Within OHIP, the Division of Program and Data Management (DPDM) and Division of Data Services and Analytics (DDSA) have experience implementing and reporting on value-based models including DSRIP and PCMH. The Division of Finance and Rate Setting (DFRS), led by the Medicaid Chief Financial Officer (CFO), is responsible for all rate setting and financing activities across Medicaid Managed Care, Medicaid Fee for Service, Child Health Plus, and the Essential Plan. DFRS will stand up a new bureau of approximately 8 people to

[54] Kirkwood, Jim. Health Information Technology- Enabled Quality Measurement Roadmap Prepared For, https://health.ny.gov/technology/qm/docs/2022_roadmap.pdf, 2022.
[55] Department of Health & Human Services, Centers for Medicare & Medicaid Services. https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_cms_ltr.pdf
[56] "Health, Department of | Agency Appropriations | FY 2024 Executive Budget." Www.budget.ny.gov, www.budget.ny.gov/pubs/archive/fy24/ex/agencies/ppropdata/HealthDepartmentof.html. Accessed 9 July 2024.

support the AHEAD project and hospital global budgeting. DDSA, comprised of 30 team members, is responsible for building and maintaining NYS DOH's health data infrastructure. OHSQA, comprised of 130 team members, supports quality reporting (including CMS Core Set Quality Measures) and measurement. OHSQA has been collecting HEDIS measures from MCOs (as outlined from the VBP roadmap) to aggregate quality results from VBP arrangements since 2018.[57] OHSQA's Center for Health Data Innovation, comprised of 31 team members, oversees the operations of the NYS APCD and SPARCS system. Additionally, it oversees a modern cloud analytic environment in close coordination with OHIP that integrates NYS APCD, SPARCS, and vital statistics data. Of these 31 team members, a data engineering and cloud development unit implements continuous integration and continuous deployment methodologies to support data pipelines and the development of analytic products for analysts.

Together, these divisions used quality measures to calculate DSRIP shared costs and QARR health plan data to measure PCMH performance and report on core measures for MMC plans. These teams are responsible for data integrity, troubleshooting, and the resolution of all data capture issues.

Ability to meet model requirements

NYS' existing data systems and planned enhancements will support AHEAD Model requirements across a) State Accountability Targets, b) metrics for Primary Care AHEAD, c) Medicaid hospital global budget methodology and operations, and d) enhanced demographic collection for health equity plans.

[57]2023 Value Based Payment Reporting Requirements. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/quality_measures/2024/docs/tech_spec_manual.pdf

For State Accountability Targets around all-payer TCOC and primary care spend, NYS will utilize the NYS APCD, which already includes claims for approximately 84% of insured beneficiaries in the state. NYS seeks to collaborate with CMS to receive non-claims data and more recent claims data on Medicare FFS beneficiaries. The State will also engage NYSHIP to intake claims and non-claims data for its members. NYS is exploring the use of the National Association of Health Data Organization's (NAHDO) Non-Claims Payment Data Layout (NCP Data Layout™) to source non-claims-based data from multiple lines of business, including MMC, commercial fully insured payers, and Medicare Advantage. For the remaining gaps, including self-insured plans, NYS will perform statistical inference on existing data. To support gap closures, the State may explore incentives for data reporting. For State Accountability quality and equity targets, the State will leverage QARR and CDC's Behavioral Risk Factor Surveillance System (BRFSS).

Primary Care AHEAD will require that primary care practices attest to building a workflow to refer Medicaid beneficiaries to the SCN. To capture this requirement, NYS will link to a new portal capturing this data. Over the longer term, NYS may enhance NYS PCMH requirements (e.g., metrics for BH integration) to further align with the goals of AHEAD and utilize QARR to capture the required data.

To support data requirements needed for execution of the Medicaid hospital global budget model, NYS plans to use a combination of NYS APCD, SPARCS, QARR, and additional data provided by CMS. NYS will partner with payers and providers to ensure that the timeliness and frequency of data collections for these sources is adequate for hospital global budget calculation and reconciliation. For quality and health equity adjustments to the budget, NYS will align closely with hospitals' quality improvement plans and health equity plans aligned to the

NYHER and AHEAD Model requirements. NYS will also update financial reporting and payment adjudication systems to operationalize a Medicaid hospital global budget.

To address enhanced demographic collection for health equity, NYS will partner with CMS for Medicare FFS beneficiaries and explore its QARR and SHIN-NY datasets, which will intake enhanced demographic data from the SCN for Medicaid beneficiaries.

NYHER allows the State to invest in technology infrastructure, conduct stakeholder outreach, and strengthen workforce capabilities in service of the SCN. The SCN's social care IT platform will serve as a care coordination solution for consenting, screening, referring, billing, paying, and tracking outcomes for Medicaid beneficiaries. It will integrate and send all social care data to the SHIN-NY statewide data infrastructure and all billing and claims to MCOs and eMedNY, a Medicaid eligibility and claims payment platform.

NYS' HIT-Enabled QM Roadmap provides a pathway for payers, QEs, health systems, and the State to improve collection of HRSN data in SHIN-NY. Additional data will allow providers to access enhanced demographic and social care information for their Medicaid members and allow them to provide better care.

Status as a health oversight agency

OHIP is a health oversight agency (HOA), as described under 45 CFR 164.512(d)(1)(ii), through its role as the state Medicaid agency as established in Article 5 of the NYS Social Services Law.

OHIP will collaborate with CMS to determine next steps to obtain timelier Medicare Personally Identifiable Information (PII) data, including FFS data for state accountability target measurement.

IX. Health equity approach

State strategies to improve health equity

NYS has developed three major strategies to address health disparities across racial, ethnic, and socioeconomic groups: a) the Prevention Agenda, b) the SCN, and c) the Health Equity Regional Organization (HERO). See *Table 12* below for additional information on these programs. To inform these programs, NYS has analyzed and reported state- and county-level health disparity data in the form of State Health Equity Reports since 2007. To encourage provider participation in health equity improvement initiatives, NYS passed legislation in 2023 requiring all health facilities to conduct Health Equity Impact Assessments (HEIA) to demonstrate the impact of planned changes on health disparities in the service area, specifically for medically underserved groups.

Table 12. Prevention Agenda, SCN, and HERO aim to improve health equity statewide

Health Equity Program	Scope	Lead agency	Timing	Approach
Prevention Agenda	Determines statewide priorities for health equity and population health initiatives	Public Health and Health Planning Council by commission of NYS DOH	Each Agenda is 5 years. Current Agenda spans from 2019-2024. Next Agenda will be established in 2025.	Recommends statewide agenda (i.e., does not include mandates or funds)
Social Care Network via NYHER	Provides Medicaid beneficiaries with "closed-loop" HRSN services and care management	OHIP	January 2024 – March 2027	$500 million for building regional SCNs + $3.4 billion for HRSN service through NYHER
Health Equity Regional Organization via NYHER	Leads regional health equity assessments, stakeholder convenings, data reporting systems,	OHIP	January 2024 – March 2027	$125 million through NYHER

	VBP model recommendations			

The New York State Public Health and Health Planning Council published its third Prevention Agenda, a five-year strategy for improving population health and health equity, at the request of the NYS DOH.[58] This document provides community health care organizations with information on statewide health equity priorities, evidence-based interventions, implementation guidance, and performance measures. The State determined agenda priority areas through statewide assessments of health disparities, input from community stakeholders, and the incorporation of local DOH Prevention Agenda items.

In January 2024, CMS approved New York's 1115 Waiver Amendment, NYHER, focused on addressing HRSN for Medicaid beneficiaries. NYHER authorized NYS to build nine new, regional SCNs with networks of social service providers and health system partners to screen, navigate, and deliver HRSN services to members in each region. SCNs will use the Accountable Health Communities Health-Related Social Needs Screening Tool to conduct HRSN screenings of Medicaid beneficiaries, including dual eligible beneficiaries, and will navigate members to HRSN services. Medicaid members who meet specific eligibility criteria (e.g., chronic conditions and SUD/SMI) will be eligible to receive enhanced HRSN services that are reimbursed through NYHER, including housing supports, nutrition, transportation, and care management. NYS will navigate all members to existing federal, state, and local programs to address HRSN needs. A critical component of the SCN infrastructure will be the creation of a statewide, multi-sector data and technology infrastructure for HRSN. The SCN will set up IT

[58] The New York State Prevention Agenda 2019-2024: An Overview, https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf, 27 Apr. 2021.

platforms to ensure secure and actionable data collection and data exchange between the State, MCOs, providers, and CBOs. SCN Lead Entities will also receive infrastructure funding to support the setup of their networks and PMPM payments to finance screenings and HRSN services. Beginning in early 2025, the Social Care Networks will be screening dual eligible beneficiaries for HRSN. SCN capacity is anticipated to grow over the life of the waiver and could be leveraged for the remaining Medicare beneficiaries in AHEAD.

In addition to the SCN, NYHER allocated $125 million to build a Health Equity Regional Organization (HERO), a singular entity tasked with developing a regional health equity strategy.[59] HERO's primary activities will include regional assessment and planning, stakeholder engagement, data aggregation and reporting, and VBP model (with HRSN) recommendations. NYS will align State Health Equity Plans (HEP) with the HERO health equity strategy to develop a singular vision of health equity for the State.

Using state health equity initiatives to support performance on statewide measures

NYS' current Prevention Agenda aligns with AHEAD's Quality and Population Health Strategy domains: population health, prevention and wellness, chronic conditions, behavioral health, health care quality and utilization, maternal health, prevention, and social drivers of health.

Examples of Prevention Agenda initiatives include strengthening opportunities to increase well-being and build resilience across demographics to improve population health, increasing vaccines and screening for breast, cervical and colorectal cancer for prevention and wellness, and promoting the use of evidence-based care to manage chronic diseases. The

[59] Department of Health & Human Services, Centers for Medicare & Medicaid Services. https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_cms_ltr.pdf

Prevention Agenda Tracking Dashboard tracks progress on a sub-county level and can be adapted to track AHEAD measures, if needed.

NYHER will supplement behavioral health, health care quality and utilization, and social drivers of health domains through its Substance Use Disorder (SUD) Program and the SCN. The newly approved SUD program will create a full spectrum of services aimed at increasing SUD treatment engagement and adherence and reducing ED readmissions. The SCN will help address HRSN through screening and navigation to services.

Statewide investments in addressing HRSN

Currently, NYS has invested in and driven stakeholder investment in HRSN through its a) Prevention Agenda, b) SCN, and c) coverage expansion of evidence-based practices.

NYS' 2019-2024 Prevention Agenda advises health care organizations to build cross-sector partnerships across public health, housing, education, and social services to address HRSNs (e.g., economic stability, education, social and community context, health and health care, and neighborhood and built environment). The State is in the process of updating the Prevention Agenda. Strong emphasis on access to primary care and effectively addressing health related social needs continue to be priorities of New York State.

NYS will continue to make investments that address HRSN through the $3.9 billion investment in the SCN—NYS' largest HRSN initiative to date. The SCN includes investments in social care IT platforms that will enable HRSN screenings, referrals, and outcomes tracking for Medicaid beneficiaries. It will integrate and send all social care data to the SHIN-NY data lake and all claims to MCOs and eMedNY. To ensure reporting is robust, NYS' HIT-Enabled Quality Measurement Roadmap provides a pathway for payers, QEs, health systems, and the State to improve collection of HRSN data in SHIN-NY. Additional data will allow providers to access

enhanced demographic and social care information for their Medicaid members and allow them to provide better care.

The State has also made several investments to expand coverage of evidence-based practices such as extended telehealth coverage beyond the COVID-19 Public Health Emergency to address transportation barriers for Medicaid beneficiary appointments.[60] Under this extension, the State added virtual patient education and eConsult coverage and expanded provider eligibility to all Medicaid providers. NYS continued to make services more accessible by expanding coverage of medically necessary Medical Nutrition Therapy (MNT) provided by qualified dietitians and nutritionists to Medicaid members.[61] Additionally, NYS Medicaid expanded eligible populations for Community Health Worker (CHW) services to include high-risk individuals (e.g., individuals with chronic conditions, those who are justice-involved, have unmet HRSN, experience community violence, are pregnant or 12-months postpartum).

Leveraging AHEAD for health equity

NYS plans to build on these current initiatives and use additional resources from AHEAD to amplify the impact of health equity activities across the state including aligning HERO and SCN activities, Hospital HEPs and the Statewide HEP. The AHEAD Model Governance Structure (MGS) will ensure that AHEAD activities are aligned with the SCN, HERO, and other State driven health care transformation initiatives. The MGS will develop the State HEP, review Hospital HEP, and review progress of AHEAD Quality and Population Health Strategy measures. NYS will align AHEAD's State Accountability targets to the State's health

[60] "NYS Medicaid Coverage of Telehealth." Www.health.ny.gov, www.health.ny.gov/health_care/medicaid/redesign/telehealth/index.htm. Accessed 9 July 2024.
[61] Dietitian/Nutritionist Policy Manual EMedNY New York State Medicaid Provider Policy Manual, https://www.emedny.org/ProviderManuals/nutritionist/PDFS/Nutritionist_Policy_Manual.pdf, 2024.

equity goals through the SCN (e.g., number of members screened and number of eligible members receiving enhanced HRSN services). To further incentivize performance in health equity, AHEAD's Medicaid hospital global budget methodology will include adjustments to payment for quality and reducing health disparities (e.g., ensuring screening and referrals). Additionally, Primary Care AHEAD practices, through their designation as PCMHs, will receive a $2-4 PMPM incentive payment for developing a workflow to refer Medicaid beneficiaries to the SCN.

X. Model governance

Description of existing and/or creation of new governance structure

The State will create a governance structure for the AHEAD Model. This governance structure will be split into two distinct entities: an Executive Committee and an Advisory Board (See *Chart 13*). This governance structure will focus NOFO-required activities such as providing technical guidance on developing the Statewide Health Equity Plan (HEP), assisting with review of the Hospital Health Equity Plans, providing input on the selection of statewide population health targets, and guiding all-payer TCOC and primary care investment targets. The governance structure will also provide input on the use of funds to support AHEAD Model activities, ensure implementation is informed by diverse perspectives, enhance performance transparency, and share AHEAD Model insights with state authorities to inform future programs or legislation.

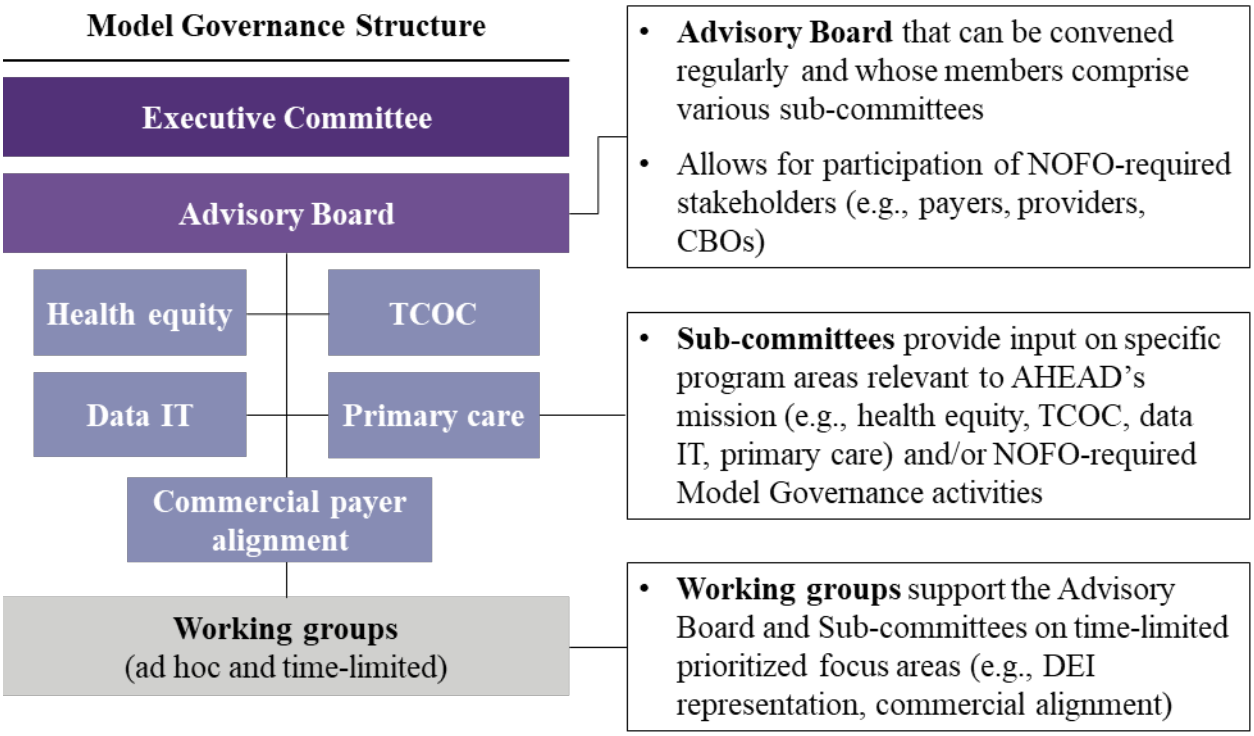
The Executive Committee will be a decision-making body comprised of individuals from DOH, the Office of the Governor, and other relevant state agencies. The Executive Committee will be granted the authority to approve health equity plans and inclusion of performance targets based on input from the Advisory Board. Executive Committee members will also be tasked with

certain administrative activities, including ensuring performance transparency and sharing AHEAD program insights with state authorities to inform future programs or legislation.

The Advisory Board will be comprised of smaller subcommittees, each with its own chair, and ad-hoc working groups (see *Chart 13*). Each subcommittee will serve the Model from pre-implementation through implementation. Subcommittee members will be asked to provide technical, programmatic, and policy input to the Executive Committee in their specific topic area. The subcommittee will be comprised of members from a wide range of entities, including, but not limited to, NYS agencies, providers, payers, tribal nations, patients from underserved communities, patient advocacy organizations, community-based organizations from underserved communities, and policy institutes. Should subcommittees lack specific subject matter expertise to address the needs of AHEAD project staff, subcommittees can invite industry experts to serve in time-limited, ad-hoc working groups. Subcommittees will have authority to determine the number of participants, the cadence of meetings, and scope of their appointed working groups.

NYS may amend this governance structure based on the evolving needs of the AHEAD Model over time. Consistent with existing State requirements, all decisions related to the AHEAD model and the Executive Committee will be subject to the approval of the Division of the Budget and Governor's Office/Executive Chamber's Office of the Director of State Operations.

Chart 13. AHEAD's Model Governance Structure will have a nested organizational structure



AHEAD leadership (Authorized Organization Representative), and the Governor's office will identify and select Executive Committee members. Thereafter, the Executive Committee will be responsible for the approval of Advisory Board subcommittees. The Executive Committee will design the Advisory Board subcommittee structure and create a preliminary list of members sourced through nominations and applications of interest. The AOR, Project Director and the Governors Office will approve the final list of subcommittee chairs and members. Once implemented, subcommittees can include select members of ad-hoc working groups as desired.

Composition of planned Model Governance Structure

NYS will invite a diverse range of stakeholders to participate on the Advisory Board, including offices from the Department of Health, other state agencies, and stakeholder groups whose members will be selected based on combination of both skills (e.g., strategic planning) and relevant subject matter expertise (e.g., value-based payments). The composition of the

Advisory Board may evolve over time, as needed. See *Table 14* for a preliminary list of candidate organizations.

Table. 14. NYS will invite a wide range of stakeholders to serve on the AHEAD Advisory Board

Stakeholder	Organization
New York State Department of Health Offices	• Office of Health Insurance Programs (OHIP) • NY State of Health • Office of Primary Care & Health System Management (OPCHSM) • Office of Health Services Quality & Analytics •
New York State agency offices	• Department of Financial Services (DFS) • Department of Civil Service (DCS) • Office of Mental Health (OMH) •
Non-government stakeholders	• NYHER entities such as the SCN and HERO may serve in advisory capacity • Payer (Medicare, Medicaid, Commercial) • Provider • Community based organizations from underserved communities • Patients and consumers • Other organizations that influence population health

Model Governance Structure role in AHEAD Implementation

The Executive Committee will focus on the overall strategy and design of AHEAD and the direction of Model Governance Structure activities as required by the NOFO (e.g., Statewide HEP). It will not weigh in on day-to-day operations. As the AHEAD Project Director and staff propose material strategy and design changes when necessary to the Executive Committee, the Executive Committee will convene for a vote when necessary to determine if a proposal passes subject to state final approval. Examples of proposals the Executive Committee might vote on include annual adjustments to hospital global budget payment methodology and the expansion of AHEAD to other downstate counties. All recommendations of the Executive Committee will be

reviewed by the New York State Division of the Budget to determine if these actions have a direct or indirect impact on New York State Financial Plan. Any Executive Committee determinations or other AHEAD Model changes that impact Medicaid spending and/or the NYS Financial Plan will be subject to the budget making process, as required by law.

The Advisory Board, composed of subcommittees, will advise the Executive Committee on programmatic components of the Model (e.g., statewide accountability for TCOC targets) via updates during Executive Committee meetings. Any input from the ad-hoc working groups will feed directly into the subcommittees to be considered for discussion with the Executive Committee.

XI. Commercial payer alignment

Current commercial payer participation in care delivery reform

Commercial payers across New York have launched multiple VBP arrangements, population health initiatives, and affordability activities in the state, as described in the *Table 15* below.

Table 15. Example value-based programs by commercial payers in New York

Payer Program	Goal	Outcome
Anthem Enhanced Personal Health Care Program	Required participating PCMH providers to serve at least 10% Medicaid beneficiaries and commit to patient-centered principles of care to receive a quality and outcomes-based enhanced fee[63]	Resulted in significant cost savings (e.g., 15% lower costs PMPM for adults), an increase in preventive services (e.g., 5% increase in HbA1c testing), and lower ED utilization (11% reduction in ED visits for adults and 17% reduction for children)[62]
Cigna Collaborative Care model	Used value-based model to incentivize providers and drive improved health,	Since 2013, model achieved $606M in savings nationally[64]

[62] Primary Care Collaborative, https://thepcc.org/initiative/enhanced-personal-health-care-program-new-york
[64] Cigna, https://www.cigna.com/static/www-cigna-com/docs/928450-state-of-value-based-care-final.pdf

	affordability, and experience[63]	
Aetna's Accountable Care Collaboration	Enhanced care coordination and lowered medical costs by rewarding physicians for meeting key VBP metrics (e.g., reducing hospital admissions, encouraging antibiotic usage) and collaborating with NYS providers, including Mt. Sinai and Weill Cornell Physicians	Covered more than 200,000 New Yorkers in value-based collaborative arrangements[65]
Humana's Medicare Advantage payment model	Used value-based incentives tied to HEDIS measures (e.g., breast cancer screening rates) and emphasized PCPs as central to the health care system[66]	In 2022, saved 23.2% in medical costs nationally[67]
Excellus Blue Cross Blue Shield's Hospital Performance Incentive Program	Rewarded achievement across quality metrics such clinical processes of care, patient safety, and patient satisfaction	36 upstate New York hospitals and health centers earned $29 million in quality improvement payments in 2020[68]
Adirondacks Accountable Care Organization (ACO)	Managed illness and improved access to primary care through partnerships with payers (e.g., NYSHIP, Capital District Physicians' Health Plan, Anthem) and providers across the Adirondack / northern New York region	Distributed $5.1M in shared savings with $4.8M distributed to network providers while generating a 6.5% overall increase in commercial performance as demonstrated by increases in colorectal cancer screening and childhood and adult immunizations[69]

[63] Cigna Collaborative Care for Specialists, https://newsroom.cigna.com/2021-02-04-Cigna-Collaborative-Care-for-Specialists
[65] Becker's Hospital Review, https://www.beckershospitalreview.com/accountable-care-organizations/aetna-mount-sinai-health-partners-launch-aco-alliance.html
[66] Mt. Sinai, https://www.mountsinai.org/about/newsroom/2016/humana-and-mount-sinai-health-partners-create-improved-care-model
[67] Humana, https://press.humana.com/news/news-details/2023/Value-Based-Care-Benefits-Patients-and-Physicians-New-Report-Shows/default.aspx#gsc.tab=0;%20https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5413213
[68] Samaritan Health, https://samaritanhealth.com/excellus-bcbs-awards-hospitals-29-3-million-for-quality-improvements/
[69] Adirondacks ACO, https://www.adirondacksaco.com/home-2022/2021-adirondacks-aco-annual-report/

Highmark's behavioral health VBP agreement with Value Network	Rewarded quality of mental health substance use disorder treatment to its members through behavioral health care collaborative with more than 100 area providers	Delivered over $500k in quality payments were delivered by 2023 after four years in the program that has also been marked by a 25% reduction in costs per member per month for commercial members by 2023 after four years in the program[70]

In 2021, the New York State of Health (NYSOH) also established a $200 million Quality Incentive Pool (QIP) for participating Essential Plan (EP) commercial health care insurers. This quality pool incentivizes payer performance on the achievement of specific quality of care and experience of care key performance indicators, leading to payouts based on the performance tier of each payer.

Regulatory authority to align commercial payers with model activities

OHIP may utilize its regulatory authority to modify contracts for state administered plans (e.g., Dual Eligible Special Needs Plans (D-SNPs), EPs, and CHIP) to align with hospital global budget payment. For other commercial payers, the State currently does not plan to utilize regulatory authority for participation. For commercial spending, the state is contemplating levers such as publicly displaying how plans compare relative to primary care spend target and their and potential considerations for how model participation is factored into the commercial rate review process.

[70] Highmark, https://www.highmark.com/newsroom/press-releases/07112023-behavioral-health-care-hits-milestone

To support commercial payer alignment with the TCOC accountability targets, NYS will evaluate potential incentives to encourage an overall reduction in health care spending across the state. NYS will consider several potential incentives for payers that have achieved TCOC goals:

- Public dissemination of information demonstrating payer impact (e.g., improvements in health and community investments)
- Promotion of compliant payers on publicly facing NYS consumer tools (e.g., plan locator ranked by success on plans achieving goals)
- Simplification of administrative steps for common payer processes with NYS (e.g., licensing)
- Pending approval from CMS, allowance of certain hospital global transformation initiatives to be counted in the plan's medical loss ratio (MLR)

Inclusion of commercial plans in global budget payments

As part of the commercial payer alignment to AHEAD, NYS will prioritize participation across state agencies (e.g., NYSOH, DFS, DCS) for other state-operated plans: EP, D-SNPs, CHIP, and NYSHIP.[71] OHIP will collaborate further with state-operated plans to plan across operational considerations (e.g., provider and member communication strategy and payment mechanisms) required to successfully implement the AHEAD Model. NYS will also invite Qualified Health Plans (QHPs) to participate in the hospital global budget model.

[71] Frequently Asked Questions, https://www.cs.ny.gov/employee-benefits/pa-market/faq.cfm#:~:text=NYSHIP%20protects%20over%201.2%20million,families%20in%20the%20United%20States.