Domain 2 Projects

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Project Objective: Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management.

Project Description: This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2. Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners,

including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.

5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.
8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

As demonstrated by the Community Needs Assessment (CNA), and as discussed at length in Section 5, the absence of integrated approaches to address the healthcare needs of our communities and the many social determinants of health adversely impacts the health status of New York City (NYC).

Potentially preventable visits (PPV) to emergency departments (EDs) are emergency visits for ambulatory care sensitive conditions (ACSCs) that may result from a lack of adequate access to care or ambulatory care coordination. Many PPVs are likely attributable to challenges related to access, patient engagement, and providers' ability to manage care provided to individual patients and across populations (see CNA need 1). Our PPS service area includes more than three million Medicaid beneficiaries and 450,000 uninsured individuals. Based on a Medicaid claims analysis provided by the NYS DOH Office of Quality and Patient Safety, we estimate that these beneficiaries account for at least 40,000 (PPVs) across NYC. In addition, risk-adjusted composite chronic illness quality indicators for the Medicaid population are 9% higher than expected (see CNA need 1). This is further evidence of our opportunity to improve quality by creating an integrated delivery system (IDS).

The CNA demonstrates a lack of access to primary care and behavioral health providers, and a lack of coordination among providers and community-based organizations (CBOs) (see CNA needs 1, 2, 4). The following comment from a Queens resident is illustrative of responses from CNA

primary data: "Overall challenges within the health system include ambulatory care provider capacity (ability to schedule appointments within an acceptable period of time as well as waiting times at the time of the appointment) and linkages and coordination within and between broader healthcare delivery systems."

The CNA highlights challenges in delivering culturally competent care and in engaging patients and families (see CNA need 3). A Brooklyn CNA respondent stated: "Some people, they have colon cancer for a long time. They discover it too late. Breast cancer. Sometimes it's too late. You can't survive because it's already spread. Why? Because they didn't get their mammograms. So our community back home, they never had these screenings, so when they come here, they never ask for it."

Finally, the CNA underscores challenges faced by NYC providers–especially public and safety net delivery providers–in ensuring appropriate care to over 1.5 million residents who either appear disengaged from the delivery system (i.e., non- and low-utilizers) or who lack insurance and thus ready access to essential non-emergency services (see CNA need 1).

To meet these community needs, we propose to accelerate development of an IDS capable of providing patient-centered care across the continuum and to target interventions that meet the needs of discrete populations and sub-populations. We will enter into formal contractual arrangements with many community-based providers and CBOs. Over time, we expect these arrangements to enable our PPS to accept financial risk for the health of populations under new, value-based payment models. In this shift, we expect to leverage our ownership of a managed care organization (MCO).

> As part of clinical transformation, we will expand primary care capacity and also work to integrate it with behavioral health. In addition, we intend to enhance or develop new resources, programs and linkages to meet community needs. We expect these efforts to include an enterprise-wide enhanced care management platform to identify, stratify, and track, and leveraging the expertise of a cadre of patient navigators, care managers, and care coordinators. In addition, we intend to expand the capacity of and enrollment in our affiliated Health Homes, and to work with primary care providers (PCPs) to attain 2014 NCQA Level 3 patient centered medical home (PCMH) recognition and meet Meaningful Use standards.

b. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Across the four boroughs that comprise our PPS service area, our assets and resources include 12 hospitals, six large Diagnostic Treatment Centers (each having achieved NCQA 2011 Level 3 PCMH recognition), four Health Homes, and a robust network of providers across the care continuum. We provide more than 43% of inpatient medical care, 41% of mental health inpatient care and 30% of inpatient detox services to NYC's Medicaid population.

We also have assets and resources that support value-based payment models and population health management. Our PPS has experience working with a diverse set of partners under innovative value-based payment arrangements, including under several risk-sharing models with leading Medicaid MCOs.

Our PPS lead, HHC, derives nearly 30% of its overall inpatient and outpatient revenues from value-based payments made by MCOs. We expect to leverage HHC's ownership of one MCO (MetroPlus) that has approximately 400,000 Medicaid members, as well as the PPS's contracting experience with other MCOs. Additional assets include successful strategies implemented as part of HHC's Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO). HHC was one of only four NYS ACOs to meet quality and cost targets. We will benefit from SUNY-Downstate, a PPS partner, and their long-standing commitment to and expertise in medical education, to equip physicians and other health professionals with tools and strategies to care for patients and families. In addition, many community-based partners have deep experience working with the most vulnerable sub-populations, including those who lack insurance or a regular provider. Our PPS will enhance these relationships and leverage their CBO experience in order to strengthen our ability to identify, engage and track our patients.

Our PPS includes NYC's largest public delivery system, and includes as partners the city agencies that administer and implement public and mental health services. As a quasi-governmental organization, we will leverage existing relationships with government agencies, CBOs, and our long-standing network of Community Advisory Boards (CABs), to deepen connections with the communities we serve. Last, and most critically, we plan to engage and mobilize the thousands of diverse and mission-focused employees of HHC and our partners, particularly their commitment to provide efficient, high-quality, and culturally competent care to all patients and their families.

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Our PPS includes a fragmented providers and organizations, with limited ability to operate as a seamless continuum of care. To address this challenge, we intend to develop a Central Services Organization (CSO) to house population health functions required for DSRIP, supported by a robust analytics and health IT infrastructure. CSO functions are expected to include: protocol management, patient engagement, risk stratification, patient navigation and care coordination. We will also help critical partners expand health IT capabilities to support linkages and data sharing. Partner contracts will establish clear expectations and incentives to manage care across the continuum.

Of our diverse patient base, many are challenged to become engaged in care and prevention. We intend to work with our partners to identify, engage, and track patients–with special focus on low- and non-utilizers and the uninsured–who represent an opportunity to reduce preventable hospitalizations and ED admissions. Working with CBO partners, we will expand PPS cultural competency and health literacy programs (see Section 7). In addition, we expect to address the social determinants of health as we engage our patients, relying on a cadre of well-trained navigators, care coordinators, and community health workers.

Our large service area challenges us to be responsive to local needs. To address this challenge, our governance structure is organized into four borough-based hubs, each with a local Project Advisory Committee (PAC) and Steering Committee to ensure PPS consistency while enabling responsiveness to local issues and opportunities. With hub and citywide members, this structure will enable us to balance local needs with broader population health goals.

Medicaid payment and regulatory barriers prevent primary care and behavioral health integration and timely, informed service delivery including resources to address social determinants of health (e.g., supportive housing). As such, we will support Greater New York Hospital Association's advocacy for appropriate payment levels and regulatory relief. We will also work to improve linkages between the healthcare and social safety net systems.

d. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

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2. System Transformation Vision and Governance (Total Possible Points – 20)

a. Please describe the comprehensive strategy and action plan for reducing the number of unnecessary acute care or long-term care beds in parallel with developing community-based healthcare services, such as ambulatory, primary care, behavioral health and long term care (e.g. reduction to hospital beds, recruitment of specialty providers, recruitment of additional primary care physicians, hiring of case managers, etc.). The response must include specific IDS strategy milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

Our goal in continuing the development of an IDS is to improve the health of all New Yorkers, and to provide culturally competent, evidence-based, person-centered care in a population health management model across the care continuum, including social and community-based services, using value-based payment models. Our IDS model places the person and the family at the center and focuses on keeping people healthy and addressing social determinants of health.

We propose to adopt an evolutionary approach to build our IDS, beginning with the development of our CSO and leveraging HHC's considerable experience in managing full-risk payment arrangements for inpatient and related services. Initially, our PPS will rely on contracted relationships with providers across the continuum to create a clinically-linked system of care that will include CBOs with expertise in addressing social determinants of health. These contracted relationships will frequently include performance incentives, allowing our partners to gain experience with hybrid models of value-based payments. Over time, as partners gain experience delivering care in a clinically-linked system, we expect that a number of contracted relationships will evolve into risk-sharing arrangements and will entail greater integration of clinical and information flows.

Consistent with this evolutionary framework, and guided by our CNA findings, we are focused on eight inter-related strategies. First, we intend to develop a CSO to support enterprise-wide care management efforts and support the many functions of DSRIP implementation. To achieve this, by year-end 2015, we expect to have a fully-staffed CSO, including a fully-operational care management information platform, complete with patient and provider registries and the ability to send and receive real-time alerts to and from our primary care and facility providers.

Second, we intend to expand our community-based primary care capacity and capabilities, with an emphasis on effective partnerships with Health Homes and engaging physicians in care management and population health. Using PPS resources, including but not limited to our primary care and managed care partners, and building on the ongoing efforts to improve access to appointments, we will increase the number of PCMH-recognized providers, and increase both the number and conversion rates of Health Home-eligible patients. We will provide training and support for provider connectivity and provider-based care management, which will also include meeting Stage 2 Meaningful Use standards.

Third, we are focused on further integration of behavioral health into primary care and related services. While a number of our primary care sites already offer the Collaborative Care model, we plan to significantly expand the number of services provided in locations with both primary care and behavioral health capacity. In a staged manner, we plan to expand and integrate across the four boroughs.

Fourth, we will implement more effective approaches to guide patients and their families through the full continuum of care, including the provision of preventive and primary care as well as the integration of post-acute providers and services. This will be accomplished through protocol-driven programs in patient navigation and care coordination and increased patient interaction with PPS-trained patient navigators, community health workers and dedicated care coordinators and care managers. Our Executive Committee will regularly monitor key performance and quality metrics related to this and other strategies, including potentially-avoidable admissions, re-admissions, and ED visits. Once our population and targets are established, the Executive Committee will establish specific annual goals for our PPS.

Fifth, deepening our existing relationships with CBOs will be essential to improving patients' health literacy and to supporting patient and family engagement. In turn, this will enable us to better address the social determinants of health, as defined by the World Health Organization as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. To accomplish these goals, we intend to enhance existing and establish new linkages to CBOs that have expertise serving their respective communities to ensure that all patients have access to the full continuum of care. Our Executive Committee, working through the Stakeholder Engagement Sub-Committee, will establish and track quarterly goals related to outreach to the uninsured and low- and non-utilizers.

Sixth, we must engage our workforce and unions to increase staff engagement, recruit and train additional staff, and offer current staff across our partners appropriate re-training and re-deployment opportunities. These activities will be central to the significant care model transformation work that DSRIP requires. As part of these activities we intend to contract for work, as needed, to augment

capacity and expertise. This will include developing contracting vehicles to ensure that incentives for partners are aligned with our PPS's population health goals. We also intend to work with other PPSs on pipeline, skills development, and the development of common job descriptions and capabilities.

Seventh, we will expand our reliance on value-based payment and contracting models, building on an already-strong foundation. Our contracting strategy with PPS partners will include, where appropriate, incentives for better patient-centered care and improved care management and care coordination. Our Executive Committee will review the current balance of fee-based and value-based payment models, and will develop concrete annual goals for the continued migration to value-based payments.

> Finally, we must identify opportunities to align inpatient capacity with emerging models of ambulatory care. Beginning in 2015, at the direction of our Executive Committee, we intend to undertake a detailed and rigorous analysis of capacity in Brooklyn, which we and others have long-identified as lacking critical ambulatory care capacity and likely having excess inpatient capacity. Working closely with NYS, NYC, our SUNY-Downstate partner, the Brooklyn Healthcare Improvement Project (BHIP) and community leaders and advocates, our IDS strategy includes appropriate actions to align Brooklyn's inpatient capacity and distribution with the steadily declining per capita reliance on inpatient care.

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

As discussed in Section 2, our governance strategy is rooted in a commitment to the communities and patients we serve. As a public hospital-led PPS, our governance structure is designed to provide: (1) a strong and effective role for community-based service organizations; (2) expert guidance to our partners to implement DSRIP projects, including Project 2.d.i; and, (3) strategic oversight and direction as we integrate our projects, investments, and partners into a single IDS that is able to provide culturally competent, evidence-based person-centered care in a population health model across the care continuum, including social and community-based services, using value-based payment models.

Our Executive Committee, advised by the Project Advisory Committee (PAC) and informed by the work of subcommittees—Care Models, Business Operations, and Stakeholder Engagement—is charged with overseeing our evolution into a successful IDS, including our ability to accept financial risk to manage the health of population and an emphasis on fulfilling our mission to serve all, regardless of ability to pay. Our governance structure will continuously review implementation, operations and performance and make adjustments as necessary.

The Executive Committee will be accountable to the PPS sponsor and to our communities for: (1) organizing projects and initiatives around the CNA-expressed needs of our patients, their families and their communities, as measured by successfully meeting the Domain 1 timing, scale, and scope targets

associated with project-specific milestones; (2) increasing the proportion of value-based payments made to major partners of the PPS, recognizing that the hospital system already derives 28% of its revenue on the basis of value-linked contracts, including full capitation; assuring timely creation of an integrated care management platform to enhance PPS partners' ability to share information and work collaboratively to help patients and their families navigate the full continuum of care (as measured by assessing the proportion of our partners with real-time connection to the platform); (3) expanding the proportion of PPS-attributed patients; (4) enhancing primary care capacity across the PPS's four borough-based hubs, with an emphasis on integrating behavioral health and primary care; (5) aligning inpatient capacity with demand, recognizing that the decline in per capita demand for inpatient services will be offset at least in part by an increased base of engaged patients resulting from Project 2.d.i outreach and engagement strategies (this work will be informed by an effort to conduct a citywide assessment of inpatient capacity and need and to estimate the net effect of declining per capita utilization with an expanded base of engaged patients); and, (6) promoting effective collaboration among partners.

With regard to subcommittee functions, the Care Models Subcommittee will be responsible for reviewing and recommending clinical processes, protocols and pathways applicable to all partners. The Business Operations and Information Technology Subcommittee will be responsible for reviewing and recommending processes and protocols for the adoption and use of information technology that will be applicable to all partners. This subcommittee will also be responsible for making recommendations regarding how DSRIP funds will be distributed, subject to the approval of the Executive Committee and HHC. The Stakeholder and Patient Engagement Subcommittee will be responsible for reviewing and recommending processes and approaches related to community and patient engagement activities.

3. <u>Scale of Implementation</u> (Total Possible Points - 20):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

5. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and links clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. Mary's Healthcare System for Children	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	St. Mary's Healthcare System for Children provides remote patient monitoring of medically complex pediatric home care patients via an interactive voice response system to identify changes in condition and lapses in medication adherence, and to prevent avoidable ED visits and hospital admissions.
God's Love We Deliver, Inc.	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Through this program, God's Love We Deliver, Inc. is tasked with increasing the number of referrals to managed long-term care (MLTC) services in NYC and expanding services to Westchester and Nassau Counties.
R.A.I.N. Inc.	Community-Based Care Transitions Program	2015	2018	R.A.I.N. provides coordination and linkage to providers who specialize in disease management.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Queens Community House (QCH)	Community-based Care Transitions Program	2013	2015	QCH has been participating as a part of the Queens Collaboration Coleman Model with participating hospitals. QCH has trained bilingual coaches who establish hospital-based communications with patients at high risk for avoidable readmission. The model includes one home visit, with follow-up calls to effect change in behaviors for better health management and linkage with a wide range of community-based services.
Total Care Pharmacy, Inc., Specialty Care Pharmacy, Amato Pharmacy, Medical Center Pharmacy, Total Care Pharmacy Bx, Inc.	Community-based Care Transitions Program	2014	2018	Total Care Pharmacy provides transitional services when patients are discharged, including follow-up on medication adherence and side effects.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

a. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The HHC ACO focuses on Medicare Fee-for-Service (FFS) beneficiaries linked to participating PCPs. Financial performance and shared savings/losses pertain to services rendered to Medicare beneficiaries only. The HHC ACO is specifically designed to deliver seamless, coordinated, high quality care to Medicare FFS beneficiaries through an organized group of HHC affiliated physicians, 11 hospitals and other healthcare providers who have agreed to work together to treat a defined population of patients across care settings–including primary and specialty care, hospitalizations and long-term care–and become accountable for the quality, cost and overall care delivered. DSRIP builds on HHC's MSSP experience by extending redesigned care processes for high quality and efficient service delivery to Medicaid patients and the uninsured.

The experience and capacity of our participating Health Homes and downstream care management and care coordination agencies, is a strong foundation for this DSRIP project. Our work will build on work already underway, but will serve a larger group of Medicaid patients, including those not currently eligible for Health Home services.

The Balancing Incentive Program provides funding to support service enhancements, such as patient monitoring to improve non-institutional long-term services and supports (LTSS). While our PPS can leverage participating providers' experiencing improving care for this specialty Medicaid population, our PPS will not duplicate activities provided by BIP funding as BIP does not target the type of chronic

disease management provided through this project.

The Community-Based Care Transitions (CBCT) supports care transitions for Medicare beneficiaries. Our PPS will leverage this experience to establish a customized, evidence-based standard care transitions for the Medicaid population in participating hospitals. Funds will not be provided if doing so would supplant or duplicate CBCT funding.

> The HARP program offers specialized managed care products with integrated medical and behavioral health services and expanded recovery-oriented benefits. HARP service providers and behavioral health enrollees are likely to participate in this project. However, this DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards the implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics.** Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.