Children and Payment and Delivery System Reform in New York State
A Policy Brief from the Children's Defense Fund – New York
May 2016

Acknowledgements

The principal author of this report was Andrew Leonard of the Children's Defense Fund – New York. Lorraine Gonzalez-Camastra and Samantha Levine, also of the Children's Defense Fund – New York, contributed significant guidance and support.

Financial support for this project was provided by the New York State Health Foundation through a subgrant administered by the Community Service Society and the Schuyler Center for Analysis and Advocacy as part of the Children's Defense Fund – New York's work with the Health Care for All New York coalition. The viewpoints expressed in this report are not necessarily those of the New York State Health Foundation, Community Service Society, or the Schuyler Center for Analysis and Advocacy.

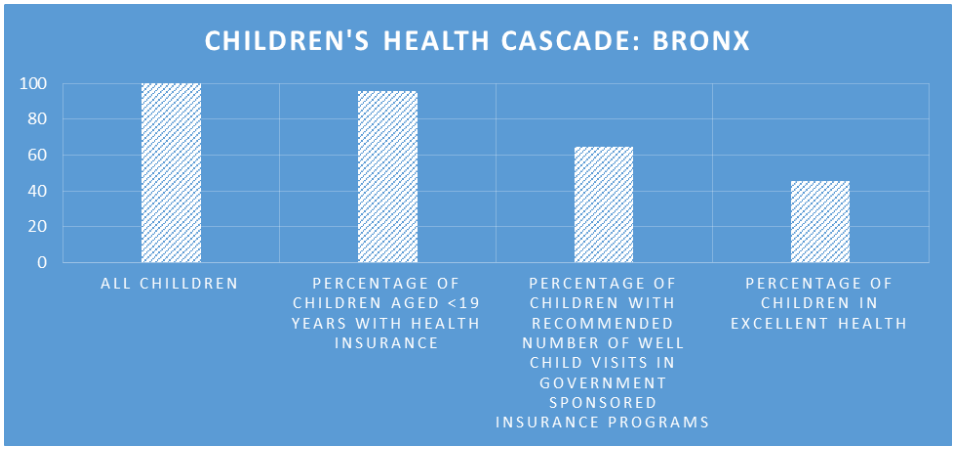
Introduction

This policy brief provides an examination of New York's recent efforts to transform the state's expensive, inefficient, and ineffective health care system into one that achieves the triple aim of health care reform – increased quality of care, improved population health, and decrease per-capita costs of care.[1] More importantly, this brief outlines how and why New York's payment and delivery system reforms (PDSR) must improve the health care delivery system for children. Presently, New York children receive more "sick care" than "health care." An overreliance on emergency room visits and inpatient hospitalizations has burdened the state with excess health care expenses, while fostering poor health outcomes among too many New Yorkers. The state's current payment and delivery system initiatives, such as the Delivery System Reform Incentive Payment (DSRIP) program and the State Health Innovation Plan (SHIP), will promote access to more integrated, primary and behavioral health care and will shift payments structures to reward the value rather than the volume of services. As the state moves forward with the implementation of these projects and others, it remains important for children's health stakeholders to highlight ways the state can protect and expand children's access to high-quality health care services. This brief concludes with a number of guiding principles for ensuring that all children have the greatest opportunities for wellness.

The Children's Health Cascade

Figure 1: The Children's Health Cascade - The Bronx

[1] New York State Department of Health. 2012. "A Plan to Transform the Empire State's Medicaid Program." https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf



In an attempt to visualize the health care deficiencies currently facing New York children, CDF-NY performed an analysis of existing state- and county-level data on children's access to affordable health coverage, the availability of high quality care, and the resultant health outcomes. From this analysis, and by borrowing from the work of Dr. Edward Gardner and his "HIV Treatment Cascade," CDF-NY has developed the "Children's Health Cascade."[2] The Children's Health Cascade shows a discouraging trend and highlights the need for major child-focused reform. In too many counties across New York State, many children have insurance, but few are connected to regular sources of high-quality primary care, and still fewer achieve the positive health outcomes desired for all children.

Figure 1 shows the Children's Health Cascade for The Bronx County, a county which, despite recent gains in community health, typifies the pattern of health care pitfalls that payment and delivery system reforms will work to address.[3] Several factors inherent in New York's existing health care delivery system contribute to the sharp declines that occur along the axis from left to right.

Access to Affordable Health Insurance

New York has consistently been a leader in the United States for ensuring access to health insurance coverage for children. Through a rigorous implementation of the Affordable Care Act (ACA) and the Children's Health Insurance Program (CHIP), and significant investments in Medicaid, New York has created a robust network of health insurance options for children. All children, regardless of immigration status, are eligible for free or low-cost health insurance in New York State.[4] Accordingly, close to 97% of all New York children have insurance and an impressive 96% of Bronx children have insurance.[5]

Health coverage must, however, facilitate access to care by covering a comprehensive set of benefits and requiring only affordable out-of-pocket payments. While Medicaid and Child Health Plus offer

[2] Gardner EM, McLees MP, Steiner JF, et al. 2011. "The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection." Clin Infect Dis (52)793–800. http://cid.oxfordjournals.org/content/52/6/793.abstract

[3] New York City Department of Health and Mental Hygiene. 2015. "Community Health Profiles Open Data 2015." Data for the Bronx County. http://www1.nyc.gov/site/doh/data/data-publications/profiles.page#rscs

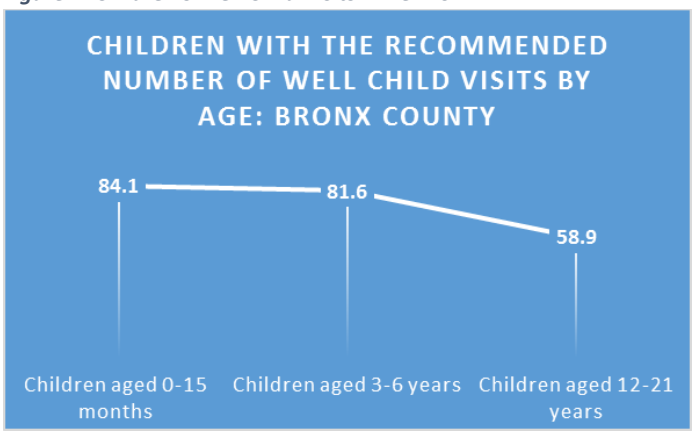
[4] New York State Department of Health. 2015. "Child Health Plus." https://www.health.ny.gov/health_care/child_health_plus/

[5] New York State Department of Health. 2013. "*New York State Prevention Agenda Dashboard - County Level"* Data for Bronx County. https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=58.

affordable health insurance coverage, the rise of high-deductible private insurance plans and the uncertain future of the CHIP program could threaten children's access to care.

Access to Primary Care

Figure 2: Children's Well Child Visits - The Bronx



Despite high rates of insurance among children across New York and even in the Bronx, consistent access to a dependable, high-quality primary care setting eludes many children. In the first 15 months of life, approximately 84% of Bronx children with public insurance receive the appropriate number of well-child visits (**Figure 2**).[6] While this number is well short of the ultimate goal of 100%, it shows that the large majority of children begin life with a strong connection to care. This figure holds steady, dropping only to about 81%, into a child's grade school years. As children mature and become more likely to develop negative health habits, their likelihood of being connected to a regular source of primary care sharply declines. On average, just 60% of adolescents with public coverage receive the recommended number of well-child visits. Research suggests the number is even lower for children with private insurance.[7]

Regular access to basic dental and behavioral health care also lags behind expectations. Among New York State Medicaid enrollees between the ages of 2 and 20, just 40% of consumers received any preventive dental care.[8] Despite the high prevalence of behavioral health conditions, research has shown that treatment uptake rates remain woefully low. One study estimated that half of 8-15 year olds living with a behavioral health disorder received no treatment in the past year.[9]

A number of neighborhood and community level issues foster an environment of inefficient care delivery and inadequate care receipt. Many neighborhoods, often those of a lower socioeconomic level, simply lack the number of providers needed to accommodate the health care needs of a population. The Health Resources and Services Administration (HRSA), the federal agency that monitors and regulates community health centers, closely tracks the supply of health care providers across the country. **Table 1** outlines the extent of provider shortage areas among six New York counties that fared poorly on pediatric quality outcome measures.[10] For the Bronx, HRSA has determined that 81% of the

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[6] New York State Department of Health. 2013. "*New York State Prevention Agenda Dashboard - County Level"* Data for Bronx County. https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=58.

[7] Ku, L. (2007). "Comparing public and private health insurance for children." Center on Budget and Policy Priorities. http://www.cbpp.org/research/comparing-public-and-private-health-insurance-for-children.

[8] "New York State Prevention Agenda Dashboard - County Level: Bronx County."

[9] Merikangas, K., He, J., Brody, D., Fisher, P., Bourdon, K., & Koretz, D. (2010). "Prevalence and treatment of mental disorders among US children in the 2001-2004" NHANES. Pediatrics, 125(1). http://www.ncbi.nlm.nih.gov/pubmed/20008426

[10] Health Resources and Services Administration. 2015. "Health Provider Shortage Area Finder," Data for Bronx, Kings, Manhattan, Broome, Fulton and Steuben counties. http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx.

census tracts in the borough have an insufficient number of primary health care providers to meet the needs of the population. As for mental health providers, the Bronx failed to meet the needs of its population in over 90% of census tracts. HRSA deemed 65% of Bronx census tracts to be insufficient for dental needs.

Table 1: Health Provider Shortage Areas by County

	Bronx*	Kings*	Manhattan*	Broome**	Fulton*	Steuben**
Primary Care Shortage Areas	81%	72%	46%	67%	100%	69%
Mental Health Shortage Areas	91%	24%	51%	100%	100%	100%
Dental Shortage Areas	65%	23%	42%	67%	0%	100%
* Percentage of census tracts considedered provider shortage areas.						
**Percentage of minor civil divisions considered provider shortage areas.						

Even if many providers operate within a consumer's geographic area, the consumer may struggle to access the appropriate care if those providers are not included in the consumer's insurance network. In recent years, health plans have leaned towards offering health insurance products with narrower networks as a means of lowering premium costs. While some consumers may appreciate the lower monthly payments, they may experience greater difficulty finding a quality provider that meets their specific health care needs.

Health Care Utilization

Table 2: Pediatric Inpatient Hospitalizations, 2013

Pediatric Inpatient Hospitalizations, by Diagnosis, 2013	
Diagnosis	**New York State**
Asthma	11,091
Bronchitis	8,181
Epilepsy/Convulsions	7,456
Mood Disorders	6,559
Pneumonia	5,981

A closer examination of pediatric hospitalizations plainly reveals how the current primary care deficiency fosters an inefficient and ineffective utilization of health care services. In lieu of adequate primary care, New York children have increasingly relied on emergency rooms and hospital admissions for care. **Table 2** shows the top five diagnoses associated with pediatric inpatient hospitalizations, excluding live child birth, across the state.[11] Not surprisingly, children frequently visit the hospital for conditions that providers could likely better manage in an outpatient, primary care setting. For example, Bronx children visit the emergency room for asthma related issues at a rate three times higher than the rest of the state.[12] Children's health providers could better reduce the frequency of asthma attacks through improved medication management and patient education in the primary care setting.

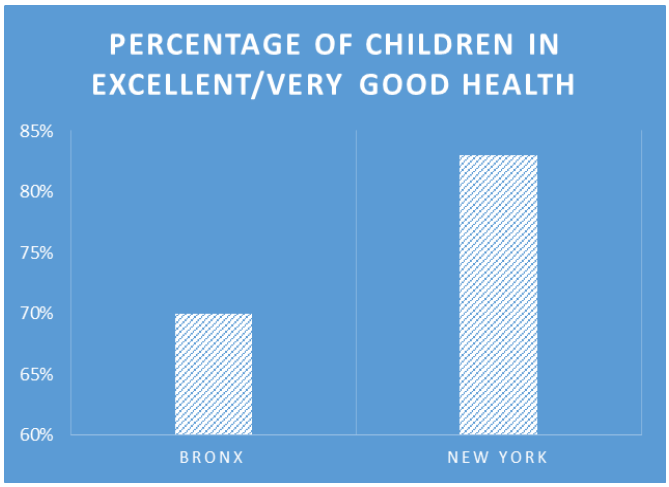
[11] New York State Department of Health. 2013. "Hospital Inpatient Prevention Quality Indicators (PDI) for Pediatric Discharges by Patient Zip Code: Beginning 2009." Data for children under 18. https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/2xc5-n3zd

[12] New York City Department of Health and Mental Hygiene. 2015. "Community Health Profiles Open Data 2015." Data for the Bronx County. http://www1.nyc.gov/site/doh/data/data-publications/profiles.page#rscs

Health Care Outcomes

Negative health outcomes closely trail the unstable care utilization patterns found in the Bronx and too many other counties across New York. The percentage of Bronx children who are in excellent or very good health falls well below the state average (**Figure 3**).[13] A multitude of factors, including, but certainly not limited to inefficient care utilization, drives this disturbing trend. One study found that medical care was only responsible for 10% of a person's health status.[14] Factors like genetics, behavior and a person's environment (housing, access to food, and others) predicted the remaining 90%.

Figure 3: Percentage of Children in Excellent/Very Good Health



Such an inefficient and ineffective health care landscape has severely hampered New York's ability to secure the best possible health outcomes for children. It will be difficult to satisfactorily transform the deeply entrenched protocols of the existing health care delivery system; however, children's health stakeholders must help diligently guide existing reforms so that they connect all children to affordable insurance, then to high-quality primary care, and finally to excellent health.

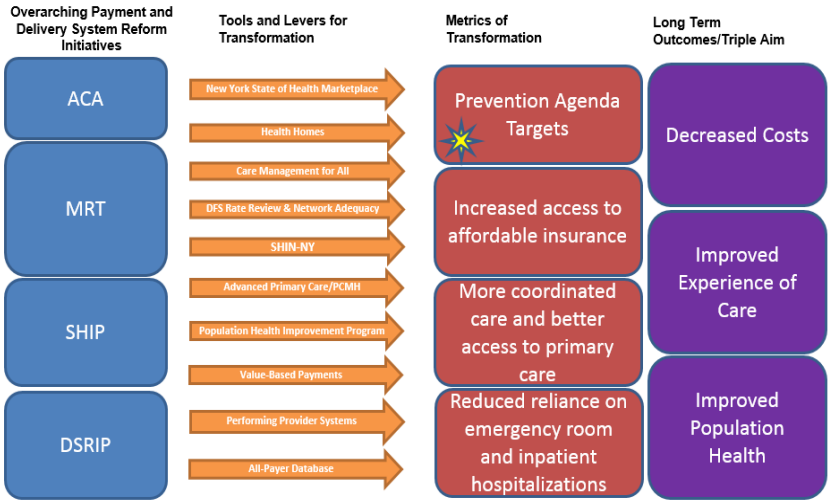
Payment and Delivery System Reform Initiatives in New York State

To date, New York has taken dramatic steps to close the gaps shown in the children's health cascade. The state seeks to create a culture of wellness among all New Yorkers; in which children have strong connections to primary and preventive care and rely less and less on higher-cost care settings, like the emergency room. New York's efforts began with Governor Cuomo's convening of the Medicaid Redesign Team (MRT) and through the state's rigorous implementation of the ACA. This work has continued with newer initiatives such as DSRIP and SHIP, among several others. **Figure 4** attempts to illustrate how the myriad PDSR projects employed by the state work together to shift New York towards a more efficient and effective health care system. A closer look at some of New York's payment and delivery system reforms helps illustrate New York's path toward increased children's wellness.

[13] New York City Department of Health and Mental Hygiene. 2009. "Child Community Health Survey 2009." Data for the Bronx County. https://a816-healthpsi.nyc.gov/epiquery/Child/CCHSIndex.html

[14] Robert Wood Johnson Foundation. 2015. "Three Emerging Challenges for Sustained Payment and Delivery System Reform."
https://www.academyhealth.org/files/FileDownloads/RWJF_AH%20Emerging%20Challenges%20FINAL.pdf.

Figure 4: Visualizing Payment and Delivery System Reform in New York State



Delivery System Reform Incentive Payment (DSRIP) Program: Through an $8 billion grant from the Centers for Medicare and Medicaid Services (CMS), New York State is implementing a program to shift health care usage away from heavy reliance on emergency rooms and inpatient hospitalization and towards integrated primary care. The primary goal of DSRIP is to reduce avoidable hospitalizations by 25% over 5 years.[15] The program incentivizes hospitals and safety-net providers to collaborate within their communities and form networks of providers known as Performing Provider Systems (PPS). These PPS networks will work together to deliver more coordinated, holistic care to Medicaid consumers through a series of clinical projects. Participating providers will receive payments for achieving certain process and outcome measures that lead towards an improved experience of care, lower overall costs, and improved health.[16][17]

State Health Innovation Plan (SHIP): While DSRIP focuses exclusively on the Medicaid population, SHIP aims to impact all health care consumers in New York State. The main goal of this $99.9 million grant is to ensure universal adaptation of the Advanced Primary Care (APC) model among all relevant providers.[18] Under the APC model, providers promote improved population health through enhanced integration of primary and behavioral health care, electronic data sharing, and coordination of care for all of their patients, as is done in the patient-centered medical home model.[19] Providers within APC practices will ultimately receive payments through a methodology that rewards high-quality outcomes for patients.[20]

Prevention Agenda: Through the Prevention Agenda, the Department of Health has laid out an aggressive plan to make New York the "healthiest state in the country."[21] Whereas the previously

[15] New York State Department of Health. 2015. "DSRIP Overview." https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm
[16] Ibid.
[17] Allen, G. 2014. "NYS DSRIP/SHIP and Population Health." Albany, NY New York State Department of Health. http://nyshealthfoundation.org/uploads/general/pop-health-summit-2014-allen-slides.pdf
[18] New York State Department of Health. 2014. "The New York State Health Innovation Plan." https://www.health.ny.gov/technology/innovation_plan_initiative/
[19] New York State Department of Health. 2015. "A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform" Albany, NY. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf
[20] Centers for Medicare and Medicaid Services. 2016. "Advanced Primary Care Initiatives." http://innovation.cms.gov/initiatives/Advanced-Primary-Care/.
[21] New York State Department of Health. 2013. "Promoting Healthy Women, Infants and Children Action Plan." https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/wic/index.htm.

discussed delivery system reform initiatives offer mechanisms through which change will occur, the Prevention Agenda lays out the objectives and longer-term goals that will help identify the success of New York's state reforms. Over 5 years, the Prevention Agenda seeks to implement five action plans to combat certain health care deficiencies. The Prevention Agenda includes an action plan, the "Promote Healthy Women, Infants and Children Action Plan" to improve children's health.[22] Within this action plan, the Prevention Agenda has specifically identified a need to boost children's access to comprehensive well-child care and reduce the high rate of dental cavities experienced by children.

Appendix A provides a more detailed description of DSRIP, SHIP and the Prevention Agenda.

Population Health Improvement Program (PHIP)[23]: As its name suggests, PHIP seeks to promote greater population health by promoting best practices among various public health stakeholders. Additionally, PHIP will work to support and advance the goals of DSRIP, SHIP and the Prevention Agenda. PHIP divides the state into eleven regions in which lead agencies will work to increase the capacity of health care stakeholders to deliver more effective, higher quality care to New Yorkers by promoting increased access to data, training, and opportunities for collaboration.

Value Based Payments (VBP): VBP is one of the pillars of DSRIP, SHIP and Medicaid Reform. By the end of the 5 year implementation of DSRIP, New York seeks to have 80-90% of Medicaid payments determined using a value-based methodology.[24] Simply, VBP arrangements are those that reward the quality, rather than volume, of services. The majority of Medicaid providers receive reimbursement, even when paid by Medicaid managed care organizations, through a fee-for-service agreement, meaning a provider receives a payment for each individual service delivered. VBP can include arrangements such as pay for performance, and provider risk-sharing, with shared savings or risk-sharing elements. One example of value-based payments is the bundled payment model, otherwise known as episode-based payments. Under this model, a pediatric provider group could receive a prospectively determined reimbursement rate for the office visits, tests, imaging and other services needed to treat a child with an acute episode resulting from a condition such as epilepsy.[25]

All Payer Database: With the creation of the All Payer Database (APD), New York seeks to promote greater transparency in the health care market by creating an accessible clearing house for provider pricing and plan reimbursement data.[26] The APD will feature information on "health care claims data from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, Medicaid and Medicare."[27] The knowledge gathered from the APD will allow providers, insurers, advocates and state officials to better assess the spending and utilization patterns in New York State. Perhaps more importantly, the APD will help consumers make decisions on plans and providers based on quality and price information.

Guiding Principles for Protecting Children in Payment and Delivery System Reform Initiatives

[22] Ibid.
[23] New York State Department of Health. 2015. "Population Health Improvement Program." https://www.health.ny.gov/community/programs/population_health_improvement/docs/overview_slides.pdf
[24] New York State Department of Health. "A Path toward Value Based Payment."
[25] Ibid.
[26] New York State Department of Health. 2011. "All Payer Database." https://www.health.ny.gov/technology/all_payer_database/
[27] New York State Department of Health. "All Payer Database."

To ensure that the various PDSR initiatives appropriately meet the needs of children, CDF-NY has developed seven guiding principles that can serve as landmarks throughout the implementation of these reforms. These principles highlight the shorter-term objectives that the state must secure before it can succeed in achieving the longer-term goals of the triple aim. They demarcate a path upon which children's health stakeholders can close the gaps that currently exist in the children's health cascade. A longer discussion of these principles and their interplay with the state's PDSR initiatives follows in **Appendix B**.

1. **Parents and children should be able to choose providers and health care services based on quality and their own preferences.** For insurance coverage to properly translate into access to care, plans must cover a comprehensive range of benefits and must not present out-of-pocket costs barriers. When parents and children can affordably access all necessary benefits, they are better equipped to make health care decisions based on quality concerns rather than cost.

2. **All children should receive regular health care through a patient-centered medical home that integrates primary and behavioral health care.** When children regularly receive care in a high-quality primary care setting, providers can appropriately diagnosis issues that would worsen without attention, can manage chronic illness, and can refer children to needed specialty services, especially behavioral health care.

3. **Children should have access to an adequate number of primary care and specialty providers who are geographically accessible and in their health insurance networks.** Compelling children to travel out of their neighborhood or to seek care outside of a narrow insurance network simply leads to higher long-term costs and poorer health outcomes. More readily accessible providers will help guarantee children do not wait for needed health care services that would otherwise become emergencies.

4. **Financing typically restricted to medical services should be expanded to fund services that address the social determinants of health.** A multitude of non-medical factors influence a child's health. Children need adequate housing, food assistance, and other social supports to be healthy. Community-based organizations provide these services for many New York children. Payment and delivery system reforms should work to better connect families with these crucial social supports and should direct funding typically reserved for health care services to community-based providers.

5. **Children's health care should be both linguistically and culturally competent.** Despite a narrowing gap between the number of insured White children and insured children of color, children of color continue to face significant health disparities across a wide spectrum of outcomes. To properly address health disparities, providers must deliver care that is both culturally and linguistically competent. Consumers struggle to achieve positive health outcomes when providers must communicate in a language in which the consumer is not fluent or comfortable.[28] Consumers' use of nearly 100 languages when enrolling on the NYSOH Marketplace demonstrates the need for significant improvements to New York's linguistic competency among providers.[29] Additionally,

[28] Goode, T., & Jones, W. (2003, revised 2004). "Definition of linguistic competence." Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. http://nccc.georgetown.edu/documents/fcclcguide.pdf

[29] New York State of Health. 2015. "New York State Open Enrollment Report 2015." Albany, NY. http://info.nystateofhealth.ny.gov/sites/default/files/2015%20NYSOH%20Open%20Enrollment%20Report.pdf.

providers who lack cultural awareness may not accurately perceive a consumer's particular manifestation of symptoms. [30]

6. **Payment and delivery system reforms must promote transparency, actively engage all parents and children and equip them to make decisions about their own care.** The lack of general health literacy and proper patient activation leads New York's health care consumers to increasingly rely on emergency rooms and inpatient hospitalizations, avoid preventive care, and even fail to adhere to needed medications.[31] Many consumers understandably feel helpless when attempting to navigate the complex health care system. Often, consumers report that their doctor, or other health care provider, is completely in charge of their health care; when in fact, consumers should be able to direct decisions about their care. PDSR initiatives must equip New York families with accessible information regarding providers, pricing, services and patient rights, and must empower them to proactively seek the care that best matches their needs.

7. **Payment and delivery system reforms should utilize appropriate reimbursement levels for pediatric service delivery and incorporate child-specific outcomes measures when evaluating the success of these initiatives.** Research has clearly documented that children are not simply little adults, and thus have unique health care needs. Accordingly, payment and delivery system reforms should incorporate child-specific clinical projects, value-based payment mechanisms and outcome metrics. To ensure that payment and delivery system reforms meet the needs of children, New York should convene a group of experts who are familiar with children's health care to develop a concrete roadmap for implementing child-specific clinical transformations, value-based reimbursement models and quality metrics.

Conclusion

New York's proud history of connecting many children to health insurance coverage, and consequently health care services, has created a foundation upon which payment and delivery system reforms can work to ensure that every child receives high-quality care that addresses the full spectrum of physical and social determinants of health. The guiding principles detailed in this brief mark a path that, if traveled strategically, will connect all New York children with the care and support they need to thrive. Through payment and delivery system reforms, New York has fostered a landscape with great potential to enhance the quality of care, improve the health of its citizens, and lower the cost of care. Ultimately, the hope for providers, payers, advocates and other stakeholders should be that of a parent, to see a child free from the burden of disease and living in an environment that promotes boundless wellness and opportunity.

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[30] Cross, T. L., B. J. Bazron, K. W. Dennis, and M. R. Isaacs. 1989. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. http://www.mhsoac.ca.gov/meetings/docs/Meetings/2010/June/CLCC_Tab_4_Towards_Culturally_Competent_System.pdf

[31] iTriage. 2015. "Tracking American Health Literacy and Prescribing Improvement: Key Findings from An Independent Survey." https://about.itriagehealth.com/wp-content/uploads/2015/02/Health-Literacy-White-Paper_February-2015.pdf

Appendix A: A Closer Look at DSRIP, SHIP and the Prevention Agenda

Payment and Delivery System Reform in New York State				
The Triple Aim: Shared Long-Term Goals of PDSR				
1. Improved Experience and Quality of Care				
2. Improved Population Health				
3. Decreased Overall Systems Costs				
Initiative	**Key Goals**	**Levers for Achieving Goals**	**Target Population**	**Timeline**
Delivery System Reform Incentive Payment Program (DSRIP)[1]	A 25% reduction in avoidable hospital use over 5 years	**Perfoming Provider Systems (PPS)** - a collaborative effort involving "hospitals, health homes, skilled nursing facilities, Clinics and Federally Qualified Health Centers, behavioral health providers, home care agencies, and other key stakeholders."[2] PPS providers will work together to deliver more coordinated, holistic care to Medicaid consumers through a series of focused clinical projects.	All New York State Medicaid Memebers	April 2015 - DSRIP Year 1 Begins April 2016 – DSRIP Year 2 Begins April 2017 – DSRIP Year 3 Begins April 2018 – DSRIP Year 4 Begins April 2019 – DSRIP Year 5 Begins April 2020 – DSRIP Concludes
	Increased collaboration among providers at the community level	**Population Health Improvement Program (PHIP)** - PHIP divides the state into eleven regions in which lead agencies will work to increase the capacity of health care stakeholders to deliver more effective, higher quality care to New Yorkers by promoting increased access to data, training and opportunities for collaboration.[3]		
	80 - 90% of payments are value-based at the end of the 5 year period	**Value-Based Payments (VBP)** - VBP arrangements are provider reimbursement mechanisms that reward the quality, rather than volume, of services.[4]		
State Health Innovation Plan (SHIP)[5]	80% of the state's population will receive care in an Advanced Primary Care setting	**Advanced Primary Care (APC)** - Under the APC model, providers promote improved population health through enhanced integration of primary and behavioral health care, electronic data sharing, and coordination of care for all of their patients, as is done in the patient-centered medical home (PCMH) model.[6]	All New Yorkers	Performance Period: January 2015 – December 31, 2018
	80% of reimbursement will be value-based	**Value-Based Payments**		
	Increased patient activation and overall transparency	**Population Health Improvement Program** **All-Payer Database (APD)** - The APD will feature information on "health care claims data from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, and Medicaid and Medicare."[7] The APD will help consumers make decisions on plans and providers based on quality and price information.		
Prevention Agenda[8]	Prevent chronic diseases Promote a healthy and safe environment Promote the health of women, infants and children Promote mental health and prevent substance abuse Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated infections.	The Prevention Agenda lays out the goals and metrics that will help identify the success of New York's state reforms. Over 5 years, the Prevention Agenda seeks to implement five action plans to combat the health care deficiencies outlined in the key goals column. The state will use all of the above mentioned levers and PDSR intiaitves to achieve the goals of the Prevention Agenda.	All New Yorkers	2013 - 2017

*New York State Department of Health. *DSRIP Overview* . Retrieved from: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm.

**New York State Department of Health. *All Payer Database* . Retrieved from: https://www.health.ny.gov/technology/all_payer_database/

Appendix A: A Closer Look at DSRIP, SHIP and the Prevention Agenda Citations

1 New York State Department of Health. 2015. “DSRIP Overview.”
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm
2 Allen, G. 2014. “NYS DSRIP/SHIP and Population Health.” Albany, NY New York State Department of Health.
http://nyshealthfoundation.org/uploads/general/pop-health-summit-2014-allen-slides.pdf
3 New York State Department of Health. 2015. “Population Health Improvement Program.”
https://www.health.ny.gov/community/programs/population_health_improvement/docs/overview_slides.pdf
4 New York State Department of Health. 2015. “A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform”
Albany, NY. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf
5 New York State Department of Health. 2014. “The New York State Health Innovation Plan.”
https://www.health.ny.gov/technology/innovation_plan_initiative/
6 Ibid.
7 Centers for Medicare and Medicaid Services. 2016. “Advanced Primary Care Initiatives.” http://innovation.cms.gov/initiatives/Advanced-Primary-Care/.
8 New York State Department of Health. 2013. “Promoting Healthy Women, Infants and Children Action Plan.”
https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/wic/index.htm.

Appendix B: The Interplay of New York's PDSR Initiatives and CDF-NY's Guiding Principles

1. Parents and children should be able to choose providers and health care services based on quality and their own preferences.		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
Affordable Care Act: New York State of Health (NYSOH) Marketplace	Through the implementation of the NYSOH Marketplace, the State has created a more affordable health insurance market for individuals, families and small businesses. Through the Marketplace, New Yorkers can enroll in Medicaid, Child Health Plus, the Essential Plan and Qualified Health Plans. Premiums for private coverage in the Marketplace are 50% lower than they were in the previous individual marketplace.[1] Nearly three million New Yorkers have gained insurance through the newly created Marketplace offerings.[2]	Currently, New York children have exceptional access to affordable, high-quality care through the Marketplace, largely because of the robust benefits and extremely low cost-sharing made possible through New York's Children's Health Insurance Program (CHIP). Despite the ACA extending CHIP authorization through 2019, Congress only renewed federal CHIP funding through 2017.[3] To ensure children maintain access to high-quality, affordable care, children's health stakeholders must: • Advocate for continued federal funding for CHIP; or, if federal funding is not renewed, • Address affordability issues for children who must receive coverage in a QHP should Child Health Plus be eliminated; o Address the "family glitch," which determines coverage affordability for a family based on the premium for a single adult; o Ensure families with children have access to additional financial assistance to lower premium and cost-sharing; • Ensure benefits for children in a QHP are equivalent to CHIP; o Modify Essential Health Benefits to reflect benefit needs that are unique to children.
Department of Financial Services (DFS): Rate Review	DFS conducts an annual review of state health insurance carriers proposed rate changes for certain health insurance products on and off the Marketplace.[4] The Department has the authority to accept or modify a plan's proposed rate increase to ensure that rates accurately and fairly reflect trends in policy, medical costs, and utilization.	For children with coverage subject to DFS rate review, children's health stakeholders should monitor the publically available rate increase proposals to assist DFS in determining whether or not the proposed rate increases fairly reflect expected cost increases.

2. All children should receive regular health care through a patient-centered medical home that integrates primary and behavioral health care.		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
Medicaid Redesign Team (MRT)	One of the key goals of the MRT was "care management for all."[5] The MRT sought to bring all Medicaid consumers away from the traditional fee-for-service model and into a managed care model. The managed care model for Medicaid consumers purports to better coordinate a consumer's care. Particularly, the managed care model attempts to promote better coordinated care by connecting each consumer with a Primary Care Provider who will manage their care.	As the state moves subpopulations of children and child-focused providers into Medicaid managed care (specifically children with significant behavioral health needs and school-based health centers), children's health stakeholders will need to provide recommendations to the Department of Health on how to best accommodate the unique needs of children within the standard managed care protocols.
Health Homes	Since 2012, the state has attempted to utilize the health home care model among Medicaid consumers.[6] The health home model is an enhanced outreach model that attempts to coordinate a patient's care by increasing collaborative data-sharing and financing among a range of providers who offer different health care services to consumers.	The state plans to enroll children in health homes beginning in October 2016.[7] The state has recognized the need to create a separate, adapted health home model for children and is seeking input from stakeholders on how to do so. Children's health stakeholders must be active participants in these conversations.
State Health Innovation Plan (SHIP)	One of the three main objectives of SHIP is to connect at least 80% of all New Yorkers to an Advanced Primary Care (APC) practice.[8] The APC model integrates behavioral health care and a population health focus into primary care. It does so by promoting greater data-connectivity among related providers and activating patients to be co-directors of their own care alongside their primary care provider.	Children's health stakeholders should work to ensure that the APC model accommodates the unique needs of children. As more children become connected to APC settings over the life of SHIP, stakeholders should monitor these settings to confirm that children have improved access to additional supports, particularly behavioral health care. Lastly, children's primary care providers should seek SHIP funding to transform their practices into APC settings.
Delivery System Reform Incentive Payment (DSRIP) Program	DSRIP is attempting to shift New York's inefficient care utilization pattern away from overreliance on the emergency room and hospitals and towards primary care. PPS networks must select one of the three following clinical projects in an attempt to better connect patients to integrated primary care: • DSRIP Project 2.a.i - Integrated delivery systems; • DSRIP Project 2.a.ii - Patient-Centered Medical Home/Advanced Primary Care; • DSRIP Project 3.a.i - Primary Care and Behavioral Health Integration.[9]	Although many DSRIP providers have focused largely on adults in their clinical projects, it remains important for PPSs to leverage DSRIP funds to better connect children to primary care. Children's health stakeholders should advise PPS networks to make sure that the primary care integration project they chose considers the primary and behavioral health needs of children. For example, a PPS network may want to explore including a school-based health center in their PPS network.

3. Children should have access to an adequate number of primary care and specialty providers who are geographically accessible and in their health insurance networks.		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
DFS: Netwok Adequacy	DFS has established minimum network adequacy requirements for plans offered within and outside of the Marketplace.[10] These requirements outline minimum primary care and specialty provider offerings within a service area and specify maximum allowable travel distances and times.	Children's health stakeholders must make sure that network adequacy standards set by DFS establish appropriate minimums regarding children's access to providers. Often times, the needs of children differ from those of adults. Additionally, stakeholders must work to guarantee that children can visit out-of-network providers when their insurance network does not include the necessary care options.
DSRIP	DSRIP recognizes the need to enhance the health care workforce to meet the needs of a transformed health care landscape. PPS networks can select from the following clinical projects to promote greater access to care: • DSRIP Project 2.c.ii - Telemedicine in Underserved Areas; and, • DSRIP Project 4.a.IIi - Strengthen Mental Health and Substance Abuse Infrastructure.[11]	PPS networks that select projects focused on expanding primary and specialty care access should consider how these projects can serve both adults and children. Just one PPS selected the telemedicine clinical project.[12] Stakeholders should monitor this initiative along with the PPS to ensure that it leads to meaningful connections to care. Several PPS networks selected the MHSA infrastructure improvement.[13] Children have significant behavioral health needs and often find themselves in the hospital because these needs have gone unaddressed. To reduce overreliance on hospital, PPS networks should work to include children's behavioral health providers in any infrastructure improvements.
SHIP	As SHIP attempts to catalyze a more efficient health care utilization landscape in New York, it understands the need to vastly increase the number of primary providers across the state. Accordingly, approximately $3 million in SHIP funding will go to workforce initiatives.[14]	Children's health stakeholders must be a critical partner in conversations regarding workforce initiatives. These conversations must consider the most efficient ways to promote improved primary, behavioral and specialty care access among children.

4. Financing typically restricted to medical services should be expanded to fund services that address the social determinants of health.		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
MRT	While seeking to curb costs in the Medicaid program, the MRT has looked at factors outside of the exam room that affect a person's health. The MRT included a workgroup on affordable housing that sought to promote improved housing stability – a major social determinant of health, among Medicaid consumers.[15] Additionally, the MRT recently created a Social Determinants of Health workgroup to address other non-medical factors that affect health.[16]	Children need a wide range of socio-economic supports to be healthy. Children's health stakeholders should further explore the use of health care dollars, even Medicaid funds, to pay for housing and should consider promoting and supplementing the recommendations made by the MRT workgroup on social determinants.
DSRIP	DSRIP understands the need to broaden the traditional definition of health. Accordingly, the Department of Health (DOH) is allowing PPS networks to commit 5% of the funding they receive to providers, such as community-based organizations, who are typically not eligible for Medicaid reimbursement.[17] The allocation of funding to non-traditional providers will allow PPS networks to address a broader spectrum of needs for their attributed patients. Additionally, PPS networks can select from one of the follow clinical projects in an attempt to address the social determinants of health: • DSRIP Project 2.b.vi - Transitional Supportive Housing; and, • DSRIP Project 3.f.i - Maternal and Child Support Programs.[18]	Children's health stakeholders must ensure that community-based organizations that address the social determinants of health affecting children have an adequate decision-making role within the governance of each PPS and that they receive funding in proportional to their impact in reducing wasteful health care utilization. Additionally, children's health stakeholders should examine the 5% cap on funding disbursed to community-based partners. While the cap is reasonable given the relevant restrictions on the use of Medicaid funds, it may be worth reevaluating this cap to accommodate a greater focus on social determinants of health.
Value-Based Payments (VBP)	VBP is one of the pillars of DSRIP, SHIP and Medicaid Reform. Simply, VBP arrangements are those that reward the quality, rather than volume, of services. VBP can include arrangements such as pay for performance, and provider risk-sharing, with upside-only or upside and downside risk-sharing. As the state outlined a roadmap for VBP in New York, it brought together a VBP workgroup subgroup on social determinants of health.[19] This workgroup developed a number of recommendations on how best to leverage VBP to focus provider attention on addressing social determinants of health.	Children's health stakeholders should promote and advance the recommendations made by the VBP subgroup on social determinants of health. As one of the recommendations suggests, the state should convene a separate workgroup to explore this issue specifically as it relates to children. Children's health providers and advocates should be an integral voice in calling for this subgroup and in all subsequent discussions.

5. Children's health care should be both linguistically and culturally competent.		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
DFS	As previously noted, DFS conducts reviews of insurance networks to ensure they adequately meet the needs of consumers.	Children's health stakeholders should ensure that network adequacy standards capture the cultural and linguistic competency capacity needed to deliver effective care to children.
SHIP	SHIP highlights the need to revamp New York's health care workforce to better meet the needs of New York's diverse communities. As previously noted, approximately $3 million in SHIP funding will go to workforce initiatives. Additionally, the expansion of APC settings should facilitate improved access to culturally and linguistic primary care for New York children.	Children's health stakeholders should draw attention to the need for the SHIP workforce funding to improve the capacity of children's providers to delivery culturally and linguistically competent care. Stakeholders must carefully envision how a reimagined health care workforce can better reflect the populations of children served in New York. Additionally, children's health stakeholders must look beyond standard racial and ethnic categorizations to discern which subpopulations of children are in need of culturally competent care, specifically unaccompanied minor children and LGBTQ youth.
MRT	The MRT Social Determinants workgroup included a recommendation calling on PPS networks to develop certified peer specialist programs.[20] These programs would employ engaged peers in the community to help other consumers navigate care. By pulling these peer specialists from the community served by the PPS, a PPS network can better incorporate cultural and linguistic competency into their care delivery mechanisms.	Children's health stakeholders must be active participants in discussions regarding the development of cultural and lingusitic competency among all PPS networks. Stakeholders will need to assist providers in developing consumer engagement materials in the language with which atrributed families are most comfortable. Additioanlly, stakeholders should work with their PHIP lead agencies to develop this capacity and to help recruit Community Health Workers reflective of the communities they serve.
DSRIP	DOH required all PPS applicants to describe, in their initial application, how they would address the cultural and linguistic needs unique to their communities. Since then, many PPS networks have been working with their regional Population Health Improvement Program (PHIP) to develop the capacity to delivery culturally and linguistically competent care.[21] Additionally, several PPS networks chose to implement one of the following clinical projects in order to offer the sort of community and peer supports described in the MRT Social Determinants workgroup's final recommendation: • DSRIP Project 2.c.i - Community-Based Health Navigation • DSIRP Project 2.d.i - Patient Activation Activities toward Community-Based Care [22]	
VBP	The VBP workgroup's social determinants of health subcommittee recommends that the state leverage value-based payments to enhance the capacity of New York providers to delivery culturally and linguistically competent care.[23] Specifically, the recommendation details a vision of New York's health care workforce that reflects the communities it serves.	

6. Payment and delivery system reforms must promote transparency, actively engage all parents and children and equip them to make decisions about their own care.		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
DSRIP	A key part of transforming New York's health care landscape through DSRIP is the ability of consumers to become more engaged in their own care. As New Yorkers become better equipped to more intentionally direct their health care choices, the state will likely see improvements to individual and population health. To promote broader patient activation, DOH listed these clinical projects among those a PPS could select: • DSRIP Project 2.c.i - Community-Based Health Navigation; and, • DSIRP Project 2.d.i - Patient Activation Activities toward Community-Based Care.[24]	Children's health stakeholders must be active participants in discussions regarding the development of peer supports for children and families. Particularly, stakeholders need to consider how peer supports change as a child matures. At a younger age, a child more likely needs peer supports aimed at their caregiver. As a child reaches adolescence, peer supports must adapt to more directly engage the adolescent.
SHIP	SHIP acknowledges the relationship between transparency in the health care marketplace and patient empowerment.[25] SHIP seeks to make available more transparent cost and quality data so consumers can be more engaged and make more informed decisions. SHIP's efforts to achieve this goal include the development of shared scorecard to evaluate payment and delivery system reform efforts and common quality metrics among providers, as well as enhanced health information technology such as the all-payer database.	Children's health stakeholders must carefully consider how to make newly released data accessible to families in New York. Health care quality and cost data must be standardized and digestible to consumers, even those with limited educational attainment. Additionally, this data should be made available online or through smart phone applications where appropriate.
All-Payer Database (APD)	With the creation of the All Payer Database (APD), New York seeks to promote the transparency of the health care market by creating an accessible clearing house for provider pricing and plan reimbursement data.[26] The APD will feature information on "health care claims data from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, Medicaid and Medicare."[27] The APD will help consumers make decisions on plans and providers based on quality and price information.	

7. Payment and delivery system reforms should utilize appropriate reimbursement levels for pediatric service delivery and incorporate child-specific outcomes measures when		
Which initiatives work to address this guiding principle?	**How does this initiative work to address this guiding principle?**	**What unique children's needs should stakeholders highlight when discussing how this intiative relates to this guiding principle?**
DSRIP	DSRIP, SHIP and VBP all rely on shifting traditional health care financing away from rewarding the volume of services delivered and towards a system that values quality outcomes and tracking those outcomes to determine the success or failure of these initiatives.	Research has clearly documented that "children are not little adults," and thus have unique health care needs.[28] Accordingly, payment and delivery system reforms should incorporate child-specific clinical projects, value-based payment mechanisms and outcome metrics. Children's health stakeholders must be active participants in all payment and delivery system reform discussions to ensure that providers appropriately adapt clinical protocols to address the needs of children, that payers develop reimbursement rates that fully cover the costs associated with the services needed to holistically treat children, and that the state adjust outcomes to reflect the unique characteristics of children so that reforms can adequately be evaluated.
SHIP		
VBP		
Prevention Agenda	Through the Prevention Agenda, the Department of Health has laid out an aggressive plan to make New York the healthiest state in the country.[29] The Prevention Agenda lays out the objectives and longer-term goals that will help identify the success of New York's state reforms. It includes an action plan, the "Promote Healthy Women, Infants and Children Action Plan" to improve children's health.[30] Within this action plan, the Prevention Agenda has specifically identified a need to boost children's access to comprehensive well-child care and reduce the high rate of dental cavities experienced by children.	Carefully discerned outcome metrics will serve to evaluate children's continued access to care throughout various payment and delivery system efforts. These metrics must carefully track children's access to care, including such measures as the number of children receiving regular well-child care and the number of child inpatient hospitalizations by diagnosis at discharge, and the resultant health outcomes. Child-specific measures will be particularly important in highlighting the need to address health care disparities. Reliable data on health care access and outcomes will demonstrate the pressing need for children of all racial and ethnic backgrounds to receive the same high-quality preventive and primary care.

Appendix B: The Interplay of New York's PDSR Initiatives and CDF-NY's Guiding Principles Citations

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