



INTEGRATED CARE WORKGROUP:

MEETING ONE
JANUARY 16, 2015

The Integrated Care Workgroup

WELCOME AND INTRODUCTIONS

RULES OF THE ROAD

1. Come to the meeting with a positive attitude.
2. Treat members with respect.
3. Be prompt arriving to the meeting and returning from breaks.
4. Turn cell phones off or to vibrate.
5. If you must take urgent calls, take your conversation outside.
6. Talk one at a time, waiting to be recognized by the Chairpersons.
7. Limit side conversations.
8. Stay on the topic being discussed.
9. Address any concerns about the discussion or the meeting with the Chairpersons.

GOALS FOR TODAY

1. Review the *landscape* – What do we know about the current state of primary care reforms and payment innovations and what more do we need to know?
2. Review the Workgroup's *goals for the next 6-12 months* and the short term deliverables, and develop a plan for achieving reform.
3. Begin discussion of long-term objectives.

The Integrated Care Workgroup

SETTING THE STAGE

New York State Health Innovation Plan



Goal Delivering the Triple Aim – Better health, better care, lower costs

<p>Pillars</p>	<p>1</p> <p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way</p>	<p>2</p> <p>Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it</p>	<p>3</p> <p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable consumers and providers to make better decisions at enrollment and at the point of care</p>	<p>4</p> <p>Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and consumer experience while controlling costs</p>	<p>5</p> <p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p>
<p>Enablers</p>	<p>Workforce strategy A Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</p> <hr/> <p>Health information technology B Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</p> <hr/> <p>Performance measurement & evaluation C Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</p>				



Department of Health

SHIP Objectives and Goals

Three Core Objectives within 5 Years:

1. 80% of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral health care;
2. 80% of the care will be paid for under a value-based financial arrangement; and,
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

We aspire to:

1. Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement within five years;
2. Achieve high standards for quality and consumer experience;
3. Generate savings by reducing unnecessary care, shifting care to more appropriate settings, reducing avoidable hospital admissions and readmissions, and ensuring a clear link between cost and quality.

SHIP CHARGE: Create a care delivery model and payment methodology to address the following:

Promote Affordable Care for All:

- 1. Patients** - affordable deductibles, copays, etc. ;
 - Premium costs in NYS increased 71% over the last decade for single coverage; 86% for family coverage.
- 2. Providers** - relatively low rates of reimbursement for primary care leading to shortages and misdistribution.
 - The HANYS 2013 Physician Advocacy Survey found that hospitals and health systems statewide need more than 1,000 additional doctors – 26 percent of them primary care physicians.
 - Doctors who practice family medicine ranked 23rd out of the 25 specialties included in Medscape's 2013 Physician Compensation Report.
- 3. Employers and Employees** - health costs continue to skyrocket:
 - Over the last decade, the cost of employer-sponsored family health insurance premiums in New York rose by an average of 92%; the employee family coverage share of premiums rose 134% (US average 94%); and deductibles increased 129%. Meanwhile median family income increased 9%.
 - New York's large employers contribute higher shares of premium costs than employers in any other state.
 - Rising premiums translate to lower wages, reduced benefits, more restricted health coverage eligibility and less affordability for employees.

*Sources: NYS Health Foundation (<http://nyshealthfoundation.org/uploads/resources/health-care-costs-section-2.pdf>) and 2003-2013 Medical Expenditure Panel Survey – Insurance Component and Current Population Surveys

SHIP CHARGE: Create a care delivery model and payment methodology to address the following:

4. Create a clear(er) link between cost and quality.
5. Support a workforce consistent with an evolved primary care infrastructure.
6. Promote cost/quality transparency to inform consumer, provider and payer decisions.
7. Align fiscal incentives to drive quality.
8. Integrate care across settings and providers to improve overall health and health care.

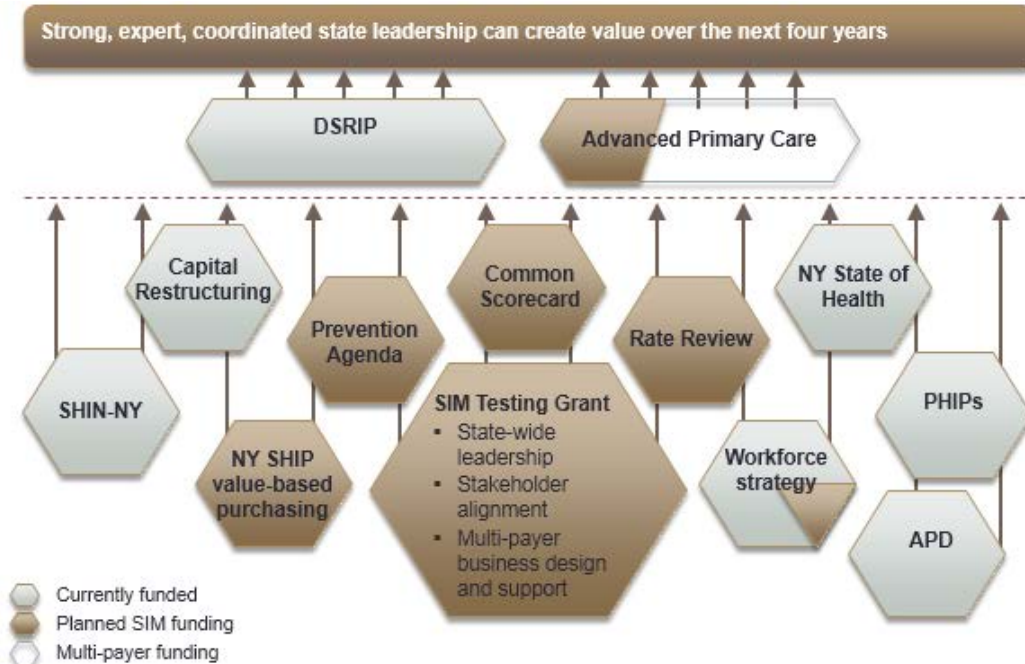
SIM Grant Application

Over the next 48 months, NYS will receive ~\$99.9 million to implement and test the SHIP.

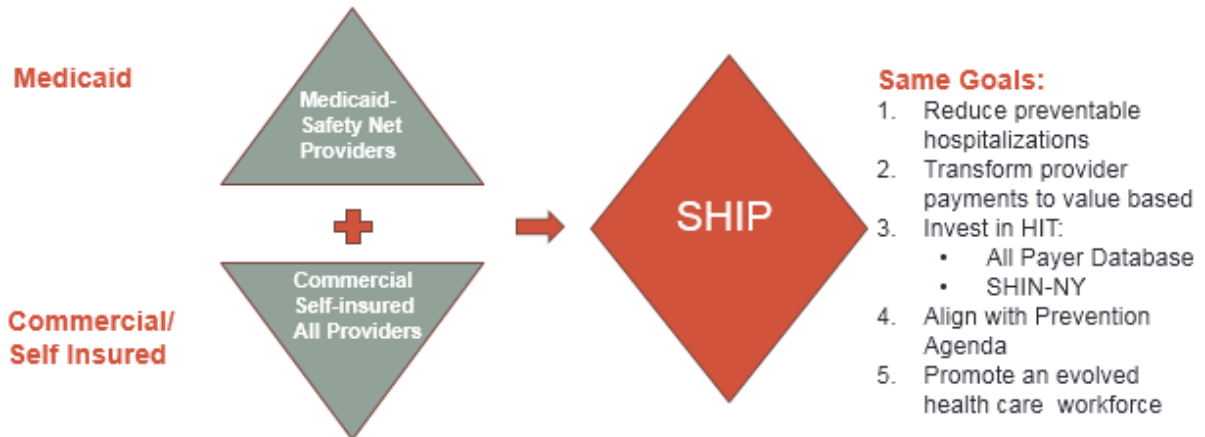
New York will promote a tiered **Advanced Primary Care (APC)** conceptual model. This model includes behavioral and population health integration, coupled with an appropriately trained workforce and engaged consumers, with supportive payment and common metrics. The state will:

- 1) Institute a statewide program of regionally-based primary care practice transformation activities to help practices across New York deliver 'advanced primary care';
- 2) Expand the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020;
- 3) Support performance improvement and capacity expansion in primary care by expanding New York's primary care workforce through innovations in professional education and training;
- 4) Integrate APC with population health through public health consultants funded to work with regional Population Health Improvement Program (PHIP) contractors;
- 5) Develop a common scorecard, shared quality metrics and enhanced analytics to ensure that delivery system and payment models support Triple Aim objectives; and
- 6) Provide state-funded health information technology, including enhanced capacities to exchange clinical data, and an all-payer database.

The SIM Grant Will Spur Innovation and Catalyze Change



SHIP & MEDICAID: Different Constituencies, Different Funding, Same Goals



SHIP and DSRIP – Complementary Efforts to Promote Health and Well-Being Through Delivery System and Payment Reform

DSRIP:

- Focus on transforming the safety net health system serving Medicaid enrollees, improving performance across the continuum, and migrating Medicaid payers from FFS to value-based purchasing (Value-Based Payment Workgroup)

SHIP:

- Focus on transforming the health system serving all populations and payers, improving performance across the continuum, and migrating most payers from to value-based purchasing
- Centerpiece is a commitment to greatly expand the adoption of the “Advanced Primary Care” model, which builds on existing initiatives (PCMH, MAPCP, CPCI, ACO, PPS, Health Home, PCIP, and more)

Near-term imperative for both SHIP *and* DSRIP is to:

- Organize, help support and deploy “practice transformation” resources, to help primary care providers achieve APC, and continue to improve their performance; and
- Work with payers to implement payment system changes that support this new model.

Integrated Care Workgroup Charge

1. Discuss APC model 'straw person' and refine through discussion
2. Initiate reimbursement model discussions - Value proposition and alignment.
3. Identify legislative requirements, if any, for adoption.
4. Begin discussion of standardized measure set.
5. Develop/recommend practice transformation core curriculum.
6. Define best practices for care coordination and delivery infrastructure.
7. Vet APC model requirements with national accreditation organizations.
8. Develop practice readiness tool and process.
9. Adopt APC model requirements.
10. Convene regional meetings to discuss/refine APC, including reimbursement model.
11. Adopt APC model for implementation, including reimbursement model.
12. Review initial six months of data to inform, revise and evolve delivery and payment systems.



The Integrated Care Workgroup

WHY WE ARE HERE

New York's Health Care System is Underperforming

Quality:

- Less than half of adults receive recommended screening and preventive care.

Continuity:

- Many patients do not today have a “usual source of care” or single trusted provider who can be highly effective in coordinating care and reducing unnecessary visits.
- Patient records are not transferred between doctors, and patients have no ability to access their own records.

Utilization and Cost:

- New York ranks last nationwide for avoidable hospital use.
- Per capita costs are among the highest in the nation and increasing.
 - Total health care costs are the 2nd highest in the nation (\$163B);
 - Spending is forecast to rise by more than 50% by 2020.
- Health care premiums are eating up real wages and harm businesses, individuals and families*.
 - NY's large employers contribute higher share of premium costs than employers in any other state.
 - Employer sponsored family health insurance cost in NYS rose 92% and employee premium contributions as a % of income doubled (over 10 years)
 - Without intervention spending on benefits for state and local government (employees and retirees) and Medicaid will continue to outpace GDP.

*Source: NYS Health Foundation – Health Care Costs and Spending in NYS (Chart Book)
<http://nyshealthfoundation.org/uploads/resources/health-care-costs-in-NYS-chart-book.pdf>

VISION: Achieve the Triple Aim and Support a “Sustainable Health System”

A Sustainable Health System is one that:

- *improves the health of our population overall*
- *uses new models of care delivery*
- *delivers care in the place and at the point of time or illness progression with a workforce working in new ways*
- *is financially responsible,*
- *works within our communities*
- *values integration*
- *measures its results*
- *treats patients and families as partners in care*
- *drives change and improvement*
- *is transparent*

Advanced Primary Care is a key tool for achieving a sustainable health system

- **A means, not an end**
- **Not the only tool**

Source: Dartmouth-Hitchcock
(http://www.dartmouth-hitchcock.org/about_dh/what_is_sustainable_health.html)

THE OPPORTUNITY

Time for Change:

- Affordable Care Act (ACA)
- Medicaid Reforms including DSRIP
- State Health Innovation Plans (SHIP)

Multiple Entities to Learn From:

- Adirondack Medical Home Project (MAPCP)
- NY Comprehensive Primary Care Initiative (CPCI)
- Finger Lakes Health Systems Agency (FLHSA)
- Primary Care Information Project (PCIP)
- NYS DOH Hospital Medical Home Project
- Payer efforts at CDPHP, Emblem, United, Empire, Medicaid and others

Our Assumptions

- 1. Improved access to high quality primary care is key to improving value in health care and achieving Triple Aim goals.**
 - But currently there is a shortage of primary care clinicians, and access to high quality primary care is uneven at best.
 - Reducing or eliminating this problem will require multiple interventions, effectively applied.
 - One important, evidence-informed intervention is an investment in helping practices change the way they deliver primary care.
- 2. Practices and payers need a compelling clinical and payment model to invest in these changes.**
 - Initially, transformation is disruptive to practices.
 - Practices need a level of 'alignment' among a sufficient number of payers to make change possible and sustainable.
 - Payers need a level of 'consistency' to implement broad care and payment changes effectively and efficiently across their network(s) and products.

Our Assumptions

- 3. A practice meeting any ‘standards’ (NCQA or otherwise) is helpful but not a sufficient guarantee of meaningful practice improvement.**
 - We aspire to have structures, processes and outcomes improve.
 - Effective use of data for patient care, practice/population management and improvement activities are fundamental to successful reform.
 - Effective use of care management, coordination, and transition supports, particularly for patients at high risk, is fundamental to successful reform.

- 4. Transformational changes in practice will remain limited if care is reimbursed on a FFS basis rewarding volume over value/quality.**
 - Change to other forms of payment will require time and a ‘path’ that manages ‘risk’ in response to practice size and capacity to succeed.
 - A standardized ‘template’ regarding transformational standards, payment approaches and measures that can be used regionally by providers and payers will help to promote and spread advanced primary care.

- 5. Maximize transformation investments by agreeing upon a model/set of milestones for Advanced Primary Care aligned with SHIP goals.**

Why We Are Here

Discussion

The Integrated Care Workgroup

ROLE OF THE WORKGROUP AND
ADVANCED PRIMARY CARE

WORKGROUP CHARGE

By Fall 2015, create standards for advanced primary care with associated payment reform options appropriate for statewide use that are:

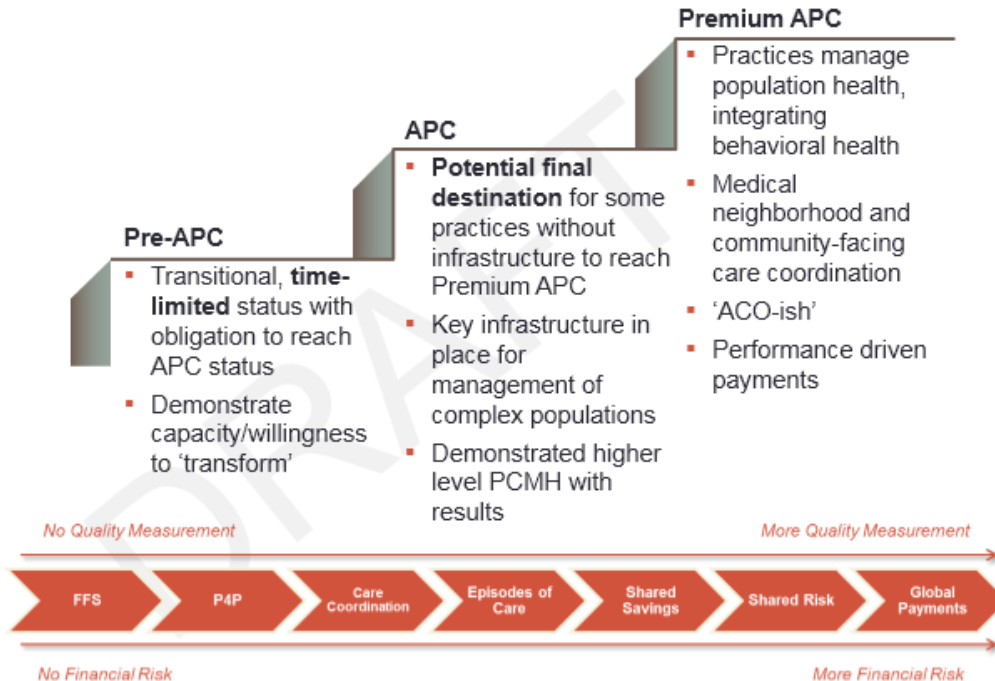
- ❖ Reasonable
- ❖ Sustainable
- ❖ Supportive of triple aim objectives
- ❖ Informative for purposes of Practice Transformation RFP

WORKGROUP GOAL

Develop an APC model that:

- Builds off of and leverages lessons from numerous existing primary care delivery models;
- Promotes health and well-being through integration of behavioral and population health, and care coordination for more efficient and effective use of health services;
- Supports DSRIP goal of increasing certification as PCMHs and/or Advanced Primary Care Models (as developed under SHIP); and,
- Creates a mutually acceptable multi-payer approach to reimbursement that results in a sustainable care model.
- Supports an evolved primary care workforce that meets future needs of an aging population with higher numbers of insured individuals; manages chronic disease and population health; effectively uses evolving health information technologies, and participates on comprehensive care management team.

SHIP Advanced Primary Care (APC) Model



A critical goal of design and implementation is for multi-payer alignment on this multi-tiered model coupled with payment support for transformation, care management AND value-based payment.



Integrated Care Workgroup Charge

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Role of the Workgroup and APC

Discussion

The Model

WHY ADVANCED PRIMARY CARE
(APC)?

APC FOUNDATION

Numerous models suggest a clear path forward

A summary of 20 studies of PCMHs found the following:

- Decreases in the cost of care (PMPM reduction), return on investment and total cost of care (61% of peer reviewed and 57% of industry-generated studies);
- Reduction in the use of unnecessary or avoidable services – ED visit reductions, and reduced inpatient admissions and readmissions
- Improvements in population health indicators and preventive measures such as better controlled HbA1c, blood pressure and LDL levels
- Improvements in access to care
- Improvements in patient satisfaction

Fundamental success of the ‘chronic care model’

- Informs all formulations of primary care reform including PCMHs, advanced primary care, health homes, medical ‘neighborhoods’

The National Context

NY LEADS THE NATION

**NCQA-Recognized PCMH Practices and Providers in the U.S.
NY and Other States as of January, 2015**

	2008 Standards	2011 Standards	Total in State	% of U.S. Total
New York	945	6,663	7,608	14%
California	154	3,329	3,483	7%
Pennsylvania	482	2,818	3,300	6%
North Carolina	669	2,096	2,765	5%
Texas	327	2,143	2,470	5%
Florida	297	2,094	2,391	5%
Massachusetts	80	2,010	2,090	4%
Illinois	444	1,307	1,751	3%
Washington	98	1,340	1,438	3%
New Jersey	328	908	1,236	2%
Michigan	24	692	716	1%
Other States	2,515	21,146	23,661	45%
U.S. Total	6,363	46,546	52,909	100%

Note: NCQA Physician Directory (<http://recognition.ncqa.org/index.aspx>) accessed Jan. 13, 2015. Data includes practices recognized as PCMHs and providers working in those practices

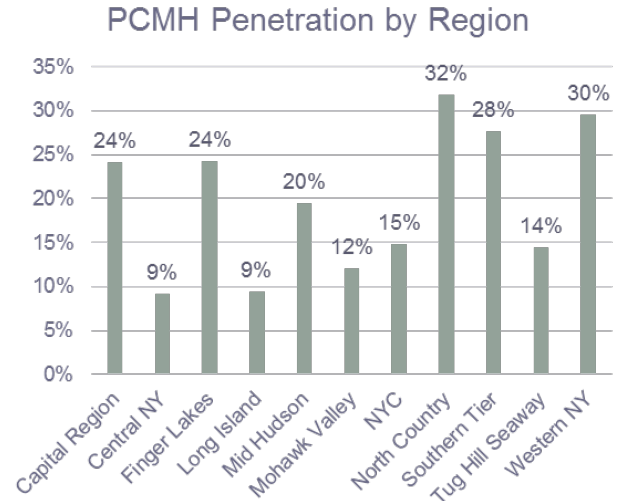
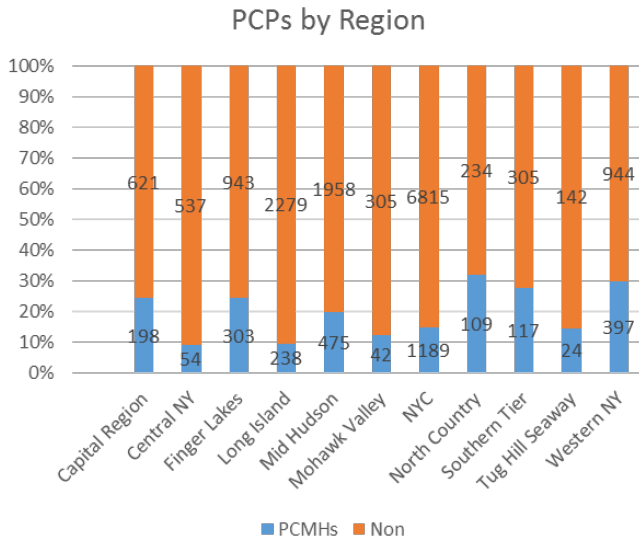


The State Context: PCMH

NCQA Recognition in NYS 2014

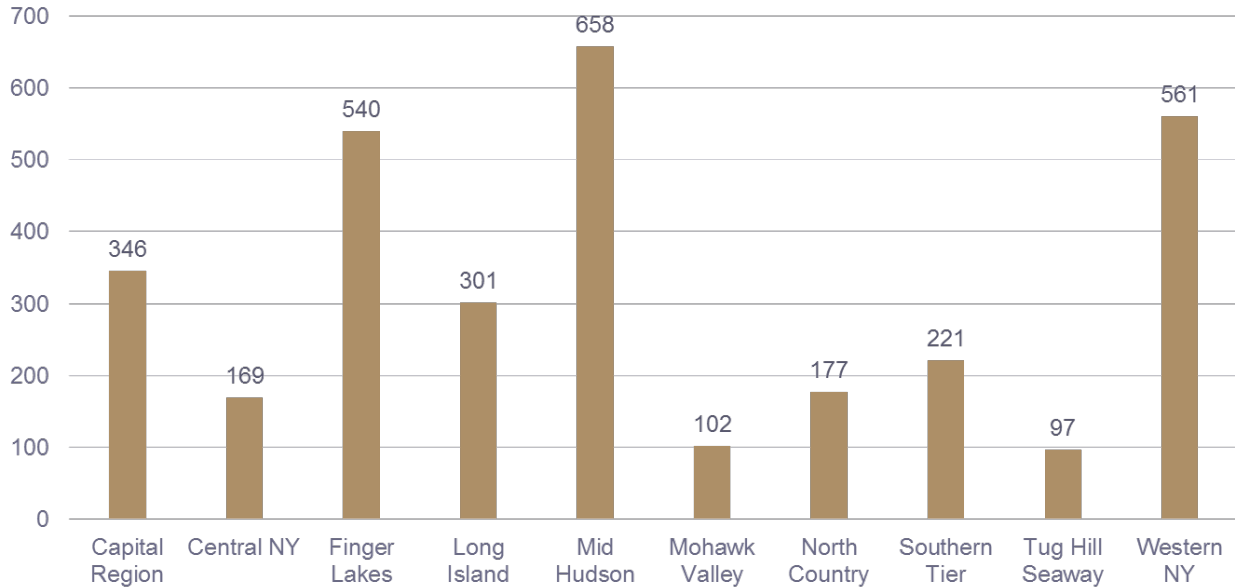
- More than 10% of U.S. primary care practices, approaching 7000 altogether, are recognized as PCMHs by the National Committee for Quality Assurance (NCQA), which has the nation's largest PCMH program.
- In New York State one quarter of all primary care practitioners are in NCQA-recognized PCMHs.
 - 5,820 PCMH-Recognized Providers
 - 6345 sites (providers can practice at multiple sites)
 - Over 90% are recognized at 'level 3' (highest level)
 - 82% are recognized under 2011 standards
 - 2014 standards are latest, but still relatively new
 - Approximately 30% of primary care providers in Medicaid plans are recognized as PCMHs
 - They take care of approximately 45% of members.

Primary Care Docs by Region & Proportion of PCMHs

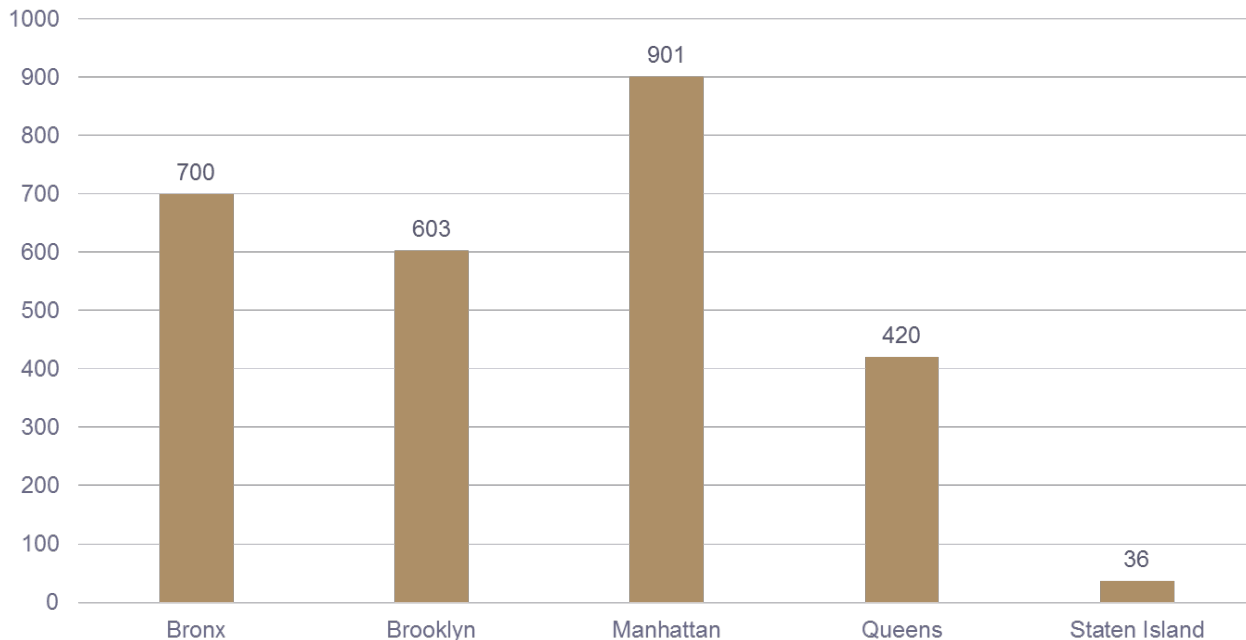


DATA FROM MOST RECENTLY AVAILABLE NCQA PROVIDER LISTS
(DECEMBER 2014) and May 2014 SK&A File

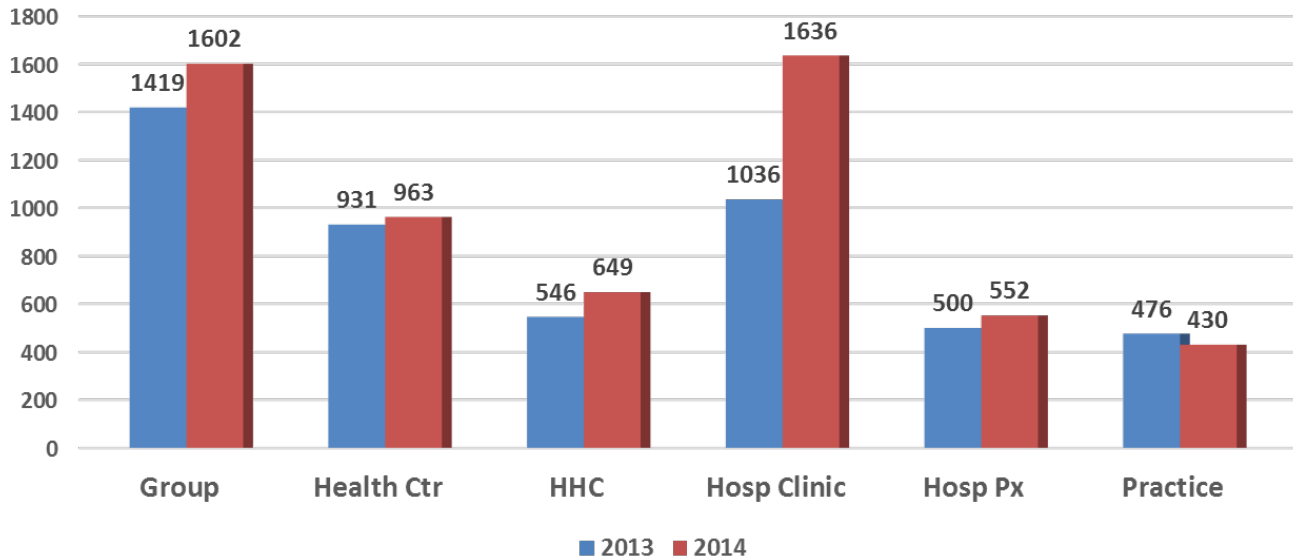
PCMH Providers by Region 2014 Non-NYC Regions (N = 3,172)



PCMH Providers in NYC by Borough - October, 2014 (N = 2,660)



Changes in PCMH Providers in NYS by Provider Type August 2013 - October. 2014



NYS PRIMARY CARE MODELS

Providing a Path Forward

Lessons learned from implementation of innovative primary care models in New York State:

Health Information Technology: Health IT is a necessary key to success. HIT capacity must be included in each of the 3 APC stages.

Practice Transformation:

A train-the-trainer model should be incorporated as part of APC development and implementation so those experienced at practice transformation can help others.

Those providing practice transformation support should be expected to:

- conduct an initial practice assessment
- routinely assess practices' progress.
- share data to encourage continuous improvement.

Payment: Payers must be engaged from the outset to align payment for practice transformation and for reimbursement of services delivered under an APC model.

- NYS should use SIM resources to support practice transformation costs; payment reform should cover ongoing costs.
- Upfront payments are critical to support transformation.
- Payment incentives must be consistent to promote desired goals and objectives.

Participants: Adirondacks ACO, NYCDOHMH; Finger Lakes Health Systems Agency; Empire BCBS; SUNY Buffalo; P2 Collaborative; Chautauqua County Health Network; Taconic IPA; Hudson Headwaters Health Network; THINC; and PCIP/NYC Reach.

Paying for Primary Care

VALUE BASED PAYMENT

WHAT IS VALUE BASED CARE?

- Pay for Performance (may be transitional)
- Care Coordination and Care Management Payments
- Episode of Care Payments
- Shared Savings
- Shared Risk
- Global Payments



Source: DFS Report (<http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf>)

HEALTH PLANS AND PROVIDERS ARE ALREADY ENGAGED IN PAYMENT REFORM

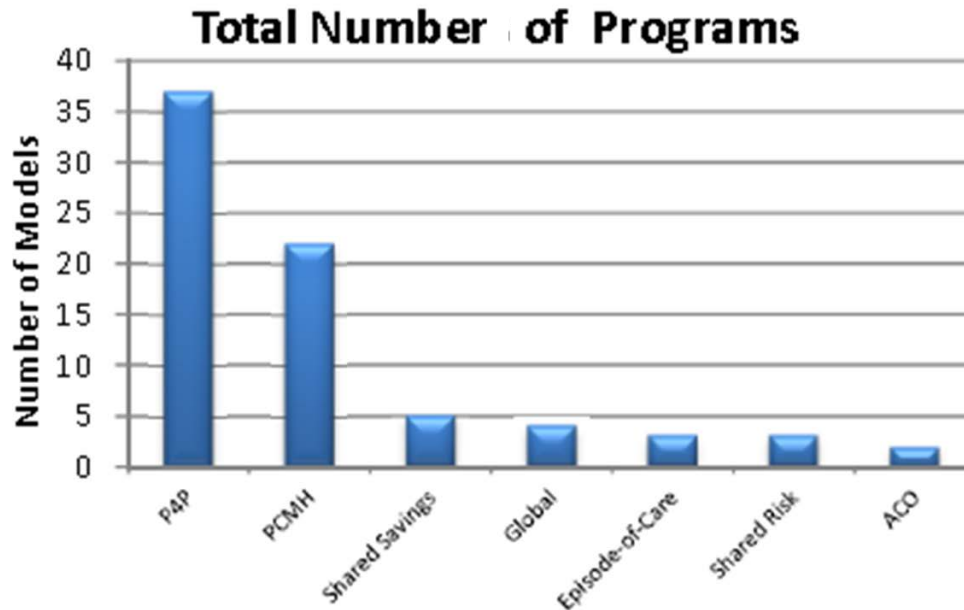
DFS Survey (published July 2014) found:

- **Variability.** All major insurers had value-based payment (VBP) programs. But they are independent with inconsistent progress.
- **Few Providers Impacted.** Just 15% of participating providers were in VBP.
- **Few Consumers Impacted.** Just 12% of insurers' members were in VBP.
- **Most VBP Programs Still Pay on FFS Basis.** Most insurers' VBP (80%) make value-based or care coordination payments *in addition to* FFS payments.
- **Pay-for-Performance (P4P) Predominates.** Almost half of VBP are "Pay-for-Performance" models.
- **Some Evidence of Savings, But Most Yet to Be Measured.**
- **Primary Care Focused.** Most of VBP models involve primary care. Specialists, hospitals, non-physician services and emergency room (ER) to a lesser degree. Lab and radiology services the least.

Source: DFS Report (<http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf>)

NYS DFS Health Plan Survey Results

76 innovative payment programs/19 insurers



19 insurers have a total of 76 pilot programs. Patient Centered Medical Home (APC) is the second most common

NYS DFS Health Plan Survey Results

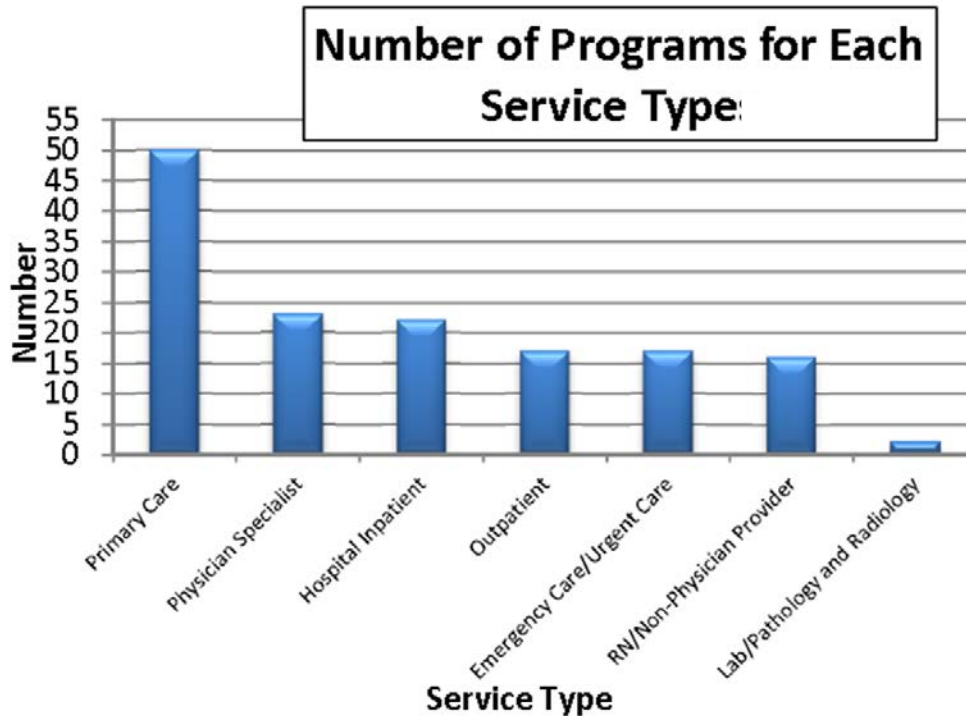
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NYS DFS Health Plan Survey Results

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NYS DFS HEALTH PLAN SURVEY RECOMMENDATIONS

- Develop a Standardized Scorecard
- Standardize Quality Measures
- Standardize Attribution Methodologies
- Increase Transparency
- Increase Value-Based Insurance Design
- Standardize Never Events
- Incentivize Use of Electronic Health Records
- Recognize Geographic Variation

DSRIP: What could a menu of options look like?

Options	Level 0 Value Based Payment	Level 1 Value Based Payment	Level 2 Value Based Payment	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population*	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Episodic Care Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient); retrospective reconciliation	Prospective Bundled Payment (with outcome-based component)
Subpopulation Capitation**	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient)	PMPM Capitated Payment for included services for subpopulation (with outcome-based component)

- Combinations are possible
- Due to lack of impact: consider to only accept Level 0 VBP for e.g. < 30% of payments
- Due to lack of impact and non-PPS focus: consider to not include silo-based VBP in DSRIP (hospital only, doctors only, etc)

* Some limited carve-outs may still remain

** Unrelated, high cost care may be carved out



Department of Health

Value Based Payment

Discussion

Presentations:

PAYER, PROVIDER, AND
CONSUMER EXPERIENCES TO
DATE

Workgroup Timelines and Deliverables

DISCUSSION OF NEXT STEPS

Timeline – 2015-2016 (1 of 3)

Month	Objectives & Goals
January 2015	<p><i>Launch Workgroup – with meeting to be convened once monthly for 12 months</i></p> <ol style="list-style-type: none"> 1) Hold first meeting: Background, Assumptions, Goals 2) Agree on goals and objectives including: <ol style="list-style-type: none"> a. Requirements/steps between levels of APC b. Designation criteria and process c. Determine key elements of care coordination for high-risk patients d. Determine how practice transformation will be defined e. Determine mental health integration requirements f. Determine if and how criteria should be adjusted for practice size g. Review, revise, and adopt timeline 3) Create sub-workgroups as necessary
February 2015	<ol style="list-style-type: none"> 1) Discuss APC model ‘strawperson’ and refine through discussion 2) Initiate reimbursement model discussions - Value proposition and alignment
March 2015	<ol style="list-style-type: none"> 1) Identify legislative requirements, if any, for adoption during 2015 (optional) 2) Begin discussion of standardized measure set 3) Refine APC model features and requirements
April 2015	<ol style="list-style-type: none"> 1) Continue discussion of standardized measure set 2) Develop/recommend practice transformation core curriculum 3) Define best practices for care coordination and delivery infrastructure 4) Review/propose legislative and regulatory actions needed (optional)

Timeline – 2015-2016 (2 of 3)

Month	Objectives & Goals
May 2015	<ol style="list-style-type: none"> 1) Develop recommendations to inform Practice Transformation RFP <ol style="list-style-type: none"> a. Eligibility requirements b. Services to offer c. Templates or standard tools to offer 2) Develop attribution recommendations – how aligned, how flexible
June 2015	<ol style="list-style-type: none"> 1) Vet APC model requirements with national accreditation organizations 2) Continue reimbursement model discussion -Determine which areas should be standardized across payers versus flexible 3) Determine criteria and application process for funds to hire care coordinators and get delivery infrastructure
July 2015	<ol style="list-style-type: none"> 1) Develop practice readiness tool and process
August 2015	<p><i>Practice Transformation RFP Released Inclusive of Practice Readiness Tool</i></p> <ol style="list-style-type: none"> 1) Adopt APC model requirements 2) Finalize practice readiness tool
September 2015	<ol style="list-style-type: none"> 1) Convene regional meetings to discuss/refine APC
October 2015	<ol style="list-style-type: none"> 1) Adopt APC model for implementation 2) Convene meetings to refine reimbursement model
November 2015	<ol style="list-style-type: none"> 1) Review results of practice readiness tool 2) Continue reimbursement model refinement

Timeline – 2015-2016 (3 of 3)

Month	Objectives & Goals
December 2015	1) Finalize reimbursement model 2) Review commitment from insurers/providers to participate in APC 3) Accelerate communications for consumers, providers, payers, employers
January 2016	Statewide and regional APC initiatives begin
February 2016	Convene regional meetings to review implementation, assess, refine and evolve model as necessary.
June 2016	Review initial six months of data to inform, revise and evolve delivery and payment systems

Next Steps

Discussion