NEW YORK STATE OF OPPORTUNITY. Department of Health

INTEGRATED CARE WORKGROUP

Meeting #7

July 31, 2015

Agenda

Timing	Topic	Lead
10:00-10:15am	Welcome and introductions	Foster Gesten / Susan Stuard
10:15-10:45am	Feedback from NEBGH and provider listening sessions	Laurel Pickering / Hope Plavin
10:45-11:15am	Core Measures Follow-up	Anne-Marie Audet
11:15a-12:15pm	Alternative Payment Models/Payment Model Straw-Person	Foster Gesten / David Nuzum
12:15-12:45pm	Working lunch	
12:45-1:45pm	Transformation RFP Decision Points/Straw-person	Foster Gesten / Marietta Angelotti
1:45-2:00pm	Closing and next steps	Foster Gesten / Susan Stuard

Welcome and Introductions

Our discussions in the next two WG meetings should facilitate alignment on strategic questions

Strategic questions for WG input

1) What are the broad elements of APC that need to be standardized on a statewide-multi-payer basis?
2) Which decisions on APC implementation will be made at a state level? At a regional level?
3) What are the aspirations for adoption of value-based payment on a multi-payer basis? What are the range of models that are constructive in supporting advanced primary care?
4) How will SIM dovetail with DSRIP, NCQA, Medicare initiatives, and others?

Operational and detailed work to be finalized later

1) What is the final set of standards and milestones, including timing and detailed understanding of which components will be standardized across the state?
2) What is the final list of measures and specifications included in a scorecard statewide?

Integrated Care Working group: status update

- **What we have accomplished so far**
  - Proposed APC Standards
  - Straw-person of Measures
  - Initial engagement with payers, employers, and providers
- **Outstanding topics** (to be discussed today)
  - Payment model
  - Milestones over time (introduction)
  - Practice transformation support
  - APC roll-out plan
- **Goal for Innovation Council** (September 22nd)
  - Comprehensive view of APC program, including refined versions of all straw models, how they fit together, and a plan for roll-out
  - Legislative, regulatory or funding recommendations in concert with other workgroups

Feedback from health plans, employers, and physician listening sessions

Regional Listening Sessions: health plans, providers, and physicians

Objectives	Process
• Provide background on SIM initiative and Advanced Primary Care • Engage and gather input from payers (health plans and self-insured employers) regional collaboratives, and primary care physicians • Build support for multi-payer approach • Provide feedback to Integrated Care Workgroup	• State-wide introductory webinar ✓ • 8 regional meetings ✓ • Follow up webinar • Health plan meeting(s) • Second round of regional meetings in Fall

Overall feedback

- Consistent support for the SIM direction
  - Value-based care
  - Strengthening and changing primary care
- Concern with scope and degree of change required
- Need for greater awareness and engagement of employers
- Some confusion regarding how SIM fits in with other initiatives

Advanced Primary Care (APC) Model feedback

- Support for the concept and belief that change is needed
- Questions about APC differentiation from PCMH concept and accreditation
- Concern about degree of transformation required, particularly given weakness of primary care profession
  - Primary care physicians are struggling, the workforce is declining and not being replaced, and primary care nurses are leaving for higher paying specialty fields
  - Small practices lack resources, infrastructure and time to engage in transformation (including the temporary loss of income during transformation)
  - Past efforts that sounded similar were ‘projects’ that were not self-sustaining
- Concern about challenge of consumer engagement
- Need for benefit design and education to support consumer engagement
- Questions about the fit of urgent care centers that are growing and displacing primary care visits

Core measures feedback

- Strong support for consistent measures, this is a reasonable set
- Overall comments and suggestions:
  - Different practices may need different metrics (e.g., pediatric versus geriatric)
  - Need to match to data available in practice EMR
  - Consider a menu approach (e.g., choose 10 out of 18)
  - Fit with Medicare measures? Link to Medicare Star measures with highest weights
  - Could metrics be customized regionally to reflect priorities of Prevention Agenda
  - Need to reward improvement over time and absolute level of performance (some practices or regions already performing better and may have less improvement opportunity)
- Numerous specific suggestions on measures were shared (e.g., additional cancer screenings, additional behavioral health measures)

Payments feedback

- Payers are making some value-based payments for primary care, at least on a pilot or project basis
- Recent experience in several regions, with data emerging on positive results (e.g., Rochester, Adirondacks, Hudson Valley)
- Need for better understanding on what level and mix of payments is needed to make APC model sustainable (for practices and payers)
- Conceptual support for multi-payer approach, but detailed work remains
- For practices, concern about cash flow and predictability (i.e., hard to manage practice if revenue is not known until after a measurement period)
- Some more detailed questions to be worked out
  - Attribution methodology
  - Fit with ACOs, where payer is already paying for primary care (and in some cases ACOs are paying for primary care on a fee-for-service basis)

Recommendations

- Increase communications, particularly regarding:
  - How all the initiatives fit together
  - APC Model and fit with PCMH concept and PCMH certification
- Continue to engage employers, including creating an Employer Advisory Council
- Engage health plans (separately from employers) to work at a more detailed level
- Engage benefit consultants, given their role working with self-insured employers
- Increase focus on consumer engagement and role of payers and providers
- Incorporate feedback into APC Model, Metrics, and Payment

Follow-Up: Measure Set for APC

Measure Set Feedback

Positives:

- Parsimony/balance.
- Measures already in wide use among practices, commercial and public payers.

Issues raised:

- Appropriateness of set for special practice settings/special populations (e.g. peds, ob/gyn, geriatrics).
- Gaps in areas of quality: substance abuse, safety, family planning, prenatal care, other cancer (breast, skin), cholesterol screening.
- Balancing measures that impact utilization and cost savings.
- Alignment with other reporting programs.
- Methodological issues: level of measurement (physician, practice, other) - numerators and valid denominators (especially for utilization measures)
- Ease of reporting (claims, MR, survey)
- Menu approach (select 10-20)
- Opportunity for improvement – regional variation.
- Timeliness of data.
- Weighing of metrics – e.g. Medicare Advantage Star system

Select Additional Measures Under Consideration and Recommendations

ICW members and other key informants nominated 7 measures of quality and 2 measures of appropriate utilization, for consideration (see attached analyses and recommendations):

1. Family planning screening/services: driver of maternal mortality.
2. Childhood developmental screening.
3. Screening for risk in the elderly (falls, cognitive decline, hearing, etc).
4. Other cancer screenings (e.g. skin, breast)
5. Cholesterol testing and control
6. Substance abuse screening and intervention.

    a. Screening, Brief Intervention, and Referral to Treatment (SBIRT).
    ***b. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

***7. Adult BMI measurement.

Select Additional Measures Under Consideration and Recommendations

Nominated Additional Utilization Measures

1. Generic vs brand prescribing.

2. Appropriate use of antibiotic (stewardship).

    a. Appropriate Treatment for Children With Upper Respiratory Infection.
    b. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis.

Revised APC Core Measures draft with expected data sources

Claims Claims + EMR Survey **New**

Prevention

1. Colorectal Cancer Screening
2. Chlamydia Screening
3. Influenza Immunization - all ages
4. Childhood Immunization (status)
5. Fluoride Varnish Application

Chronic Disease (Prevention and Management)

6. Tobacco Use Screening and Intervention
7. Controlling High Blood Pressure
8. Diabetes A1C Poor Control
9. Appropriate Medication Management for People with Asthma
10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents **and adults**

Behavioral Health/Substance Abuse

11. Depression screening and management
12. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

Patient Reported

13. Record Advance Directives for 65 and older
14. CAHPS Access to Care, Getting Care Quickly

Appropriate Use

15. Use of Imaging Studies for Low Back Pain
16. **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**
17. Avoidable Hospitalization
18. Avoidable readmission
19. Emergency Dept. Utilization

Cost of Care

20. Total Cost Per Member Per Month

- **What are the right sources for these measures?**
- **Would RHIOs be the right partners for electronic measures?**

APC Measure Set Next Steps

- Continue to refine common core measure set
- Begin to address issues regarding implementation:
  - Data sources - registries
  - Timeframes
  - Level of measurement
  - Payment models

Measures - questions for discussion

Strategic questions for WG input

1) Should payers be required to utilize all measures, or just some mandatory subset, in designing payment models?
2) Should payers be able to add measures of their choosing?
3) What degree of flexibility should payers have to customize payments as a function of the measures attained?
4) Which decisions on measurement should be made at a regional level?
5) Does our approach reflect sufficient alignment with DSRIP and Medicare Advantage?

Operational and detailed work to be finalized later

1) What is the final set of exact measures to be included in the APC scorecard?
2) What is the detailed design for the reporting system?
3) How do we ensure measures are quality controlled (e.g., sufficient sample size for statistical validity)?
4) Which measures should be compared to benchmarks (from within State or external)?
5) Should collection and reporting be centralized or disaggregated? What are the options technologically and potential tradeoffs?
6) How can we best support regions that are ready to operationalize the scorecard?
7) Who should be able to see reports?

Payment Models Discussion

Payment - questions for discussion

Strategic questions for WG input

1) How should we think about the relationship of standards (and tiers) and measures to payment approaches (e.g. care management payments, risk sharing, and P4P)?
2) What are your thoughts about how to balance provider need for 'alignment' among payers with payers need for 'flexibility'?
3) Which decisions on payment should be made at a state vs. a regional level?
4) How important is it to align APC payment approaches with other payment models (e.g. Medicare ACOs, APC/CPC Model and Medicaid DSRIP)?
5) What are implications for smaller practices?

Operational and detailed work to be finalized later

1) What are the final terms of a multi-payer compact?
2) What is the final set of milestones with associated timing and connection to specific payment terms?
3) What set of payment contracts could exist within this program, and how do they relate to measures?

Goals and Principles for Payer Alignment

- **Multi-payer alignment**. Health care cost containment (and therefore affordability) cannot be achieved without delivery and payment system transformation across multiple aligned payers covering a critical mass of provider panels.
- **Flexibility**. Payment models should be flexible enough to accommodate practice's and payer's individual needs and capabilities.
- **Supporting the transition.** Payment models should support initial investments necessary to succeed in alternative payment models, contingent on meeting agreed-upon milestones.
- **Rewarding quality**. The payment models should measure and reward the delivery of high quality primary care delivery.
- **Sharing Savings**. Savings that result from high quality primary care delivery should be shared by patients, providers and payers.
- **Transition away from FFS model**. Moving away from fee-for-service may be a transitional process and not happen all at once.
- **Identifying what "counts**." The SHIP's goal of 80% value-based coverage will require identification of what types of payment models count towards that benchmark.

The DSRIP / SHIP VBP workgroup will help coordinate Integrated Care payment plans with other VBP initiatives in NYS

VBP discussion timing

- **Medicaid / DSRIP**: Summer-Fall 2015
- **APC payment model within Integrated Care workgroup**: Summer-Fall 2015
- **Medicaid / DSRIP and APC alignment with Medicare**: Fall 2015
- **Medicaid / DSRIP primary care subgroup**: Fall 2015
- **VBP for broader commercial market**: Winter-Spring 2016

For discussion: framework for types of financial investments and how SIM and participating payers may contribute to each

Draft model of financial support by tier

Type of investment	Pre-APC	APC	Premium APC
Practice trans-formation support	▪ PT support (through vendors) ▪ Milestone payments	▪ Possible light-touch support	
Care management fees	▪ Potential PMPM payments for pre-APC practices achieving initial set of milestones	▪ PMPM payments	▪ PMPM payments
Outcomes-based payments *(examples of MINIMUM models)*	▪ Limited P4P based on outcome measures	▪ Upside-only risk sharing payments with quality gating	▪ Upside and downside risk-sharing with quality gating ▪ Integration with ACO arrangements

- What kind of **initial investments** can practices be expected to make prior to receiving support for the APC transformation (e.g. identification of a transformation leader / champion, care coordinators, EHR, population health software)?
- Do practices have to achieve all elements of APC before **care coordination fees** kick in? If not, what components would be necessary to justify PMPM payments?
- At what point should **outcomes-based payment** be included in the model?

Many multi-payer programs begin PMPM support early in the transformation process

Multi-payer milestone examples[1]

	1 Entry	Sample milestones with no financial support → 2 Qualification for PMPM support	Sample milestones with PMPM support → 3 End-point
Arkansas SIM		▪ None	▪ 24/7 access ▪ Connect to HIE ▪ Develop and implement strategies for care coordination
Delaware SIM		▪ 24/7 access ▪ Identifying 5% of highest-risk patients ▪ Implement plan for follow-up post-discharge	▪ Implement multi-disciplinary care team for high-risk patients ▪ Implement plan for contacting patients in need of preventive care
Rhode Island CCSI		▪ EHR (entry criteria) ▪ Hire nurse care-manager (entry criteria)	▪ Hire nurse care managers ▪ Implement EHR ▪ Demonstrate use of evidence-based care
CPCI		▪ EHR (entry criteria) ▪ (plus 50% of panel covered by participating payers)	▪ 24/7 access ▪ Care management for 80% of high-risk patients ▪ Implement shared decision-making

- What subset of APC standards would be sufficient for NYS payers to begin investing in primary care practices (contingent on meeting subsequent milestones)?
- What is an appropriate time period for each of these sections?
- What workflow changes could be done without critical staff such as care managers?
- How should practice-transformation support line up with financial support from payers?

1 Details of milestones in appendix

Source: Expert interviews, State and CPCI websites

Elements of multi-payer support – a mix of aligned and varying elements

Aligned elements
Vary by payer

Objective is to ensure a minimum degree of alignment of payer models to support APC, in order to create consistency and efficiencies of scale for APC providers

	Example components
Eligibility for program	▪ Minimum status of pre-APC
Measurement	▪ All metrics chosen from APC core measures
Payment over time	▪ Initial process and tier payments phase toward outcome-based payments over time
Cost of care	▪ Minimum: One measure of cost of care or utilization (e.g. total cost of care, components, admissions)
Quality	▪ Minimum: 80% of incentive weight tied to core measure set
Shared savings	▪ Minimum APC: Upside gain-sharing ▪ Minimum premium APC: Upside and downside risk-sharing
Baseline spend/ growth	▪ Vary by contract
Minimum savings to qualify for payment	▪ Vary by contract
Terms of value-based payment	▪ Vary by contract

- What level of payer consensus and support for new care delivery models is necessary to catalyze a change in primary care's day-to-day practice of medicine?
- What parts of payment can vary between payers with fewer negative impacts on primary care practices?

Examples: payers may develop different business arrangements within a multi-payer program

Aligned elements
Vary by payer

	Payer A	Payer B	Payer C
Eligibility for program	▪ Minimum status of pre-APC	▪ Minimum status of pre-APC	▪ Minimum status of pre-APC
Measurement	▪ All metrics chosen from APC scorecard	▪ All metrics chosen from APC scorecard	▪ All metrics chosen from APC scorecard
Payment evolution	▪ PMPM payments in pre-APC contingent upon meeting milestones and in higher tiers, phasing into outcomes-based payments	▪ PMPM payments in pre-APC contingent upon meeting milestones and in higher tiers, phasing into outcomes-based payments	▪ PMPM payments in pre-APC contingent upon meeting milestones and in higher tiers, phasing into outcomes-based payments
Cost of care	▪ Total cost of care: medical, pharmacy, & behavioral health but excluding LTSS	▪ Total cost of care: medical & pharmacy; excludes be-havioral health and LTSS	▪ Total cost of care: medical only
Quality	▪ 10 scorecard quality metrics; must pass all to be eligible for shared savings	▪ All scorecard quality metrics, must pass 90% to be eligible for shared savings	▪ 5 scorecard quality metrics, must exceed 60th percentile nationally for shared savings eligibility
Shared savings	▪ 30% upside only ▪ 10% of total reimbursement cap	▪ 50% upside and downside ▪ 20% of total reimbursement cap	▪ 50% upside only ▪ 15% of total reimbursement cap
Baseline spend / growth	▪ 2 year baseline ▪ 2% trend	▪ 2 year baseline ▪ 1.5% trend	▪ 2 year baseline ▪ 3% trend
Minimum savings for payment	▪ 2 percentage points	▪ 0 percentage points	▪ 1 percentage point
Terms of value-based payment	▪ Retrospective adjustment off of FFS	▪ Quarterly payments	▪ PMPM payments based upon quality and cost performance

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Practice Transformation RFP

Practice transformation - questions for discussion

Strategic questions for WG input

1) What elements of practice support are most critical for transformation?
2) What is the minimum duration of practice support that can enable practice success in APC?
3) Can providers serve as practice transformation vendors?
4) Who should certify practice progress toward milestones?
5) What are the governance responsibilities that will ensure that vendors are accountable to the SHIP goals?

Operational and detailed work to be finalized later

1) Which vendors are best-suited to deliver PT support?
2) What should be the final terms of a vendor contract?
3) What is the final curriculum for practice transformation support?

Practice Transformation support– disclaimer for WG input

- We are aware that participants in this working group may choose to be applicants to a Practice Transformation RFP. Today's conversation is not privileged.
- Once the RFP is released, additional discussion on the RFP will not be possible in this working group, and clarifying questions will need to be posed through the official question and answer channel

The NYS primary care landscape is heterogeneous and many practices are not prepared to accept value based payment

- **One quarter of primary care providers in NYS are in NCQA-recognized PCMHs**
- **Only 34.1% of payments are value-based**, despite the existence of 76 value based programs among 19 payers
- **EMR adoption amongst NY physicians is 39.6%,** significantly lower than the national average of ~48%

Source: NCQA, Catalyze Payment reform 2015, DFS report, CDC/ National Center for Health Statistics report ("Use and Characteristics of EHR Systems Among Office-based Physician Practices: U.S., 2011-2013"); National Ambulatory Medical Care Survey

Practice transformation support will help Pre-APC practices meet APC standards and succeed in value-based payment models

Pre-APC practices

- Interested in succeeding on alternative payment contracts, but currently in FFS
- Has invested in EMR
- Committed to a future team-based care model

SIM-funded practice transformation support

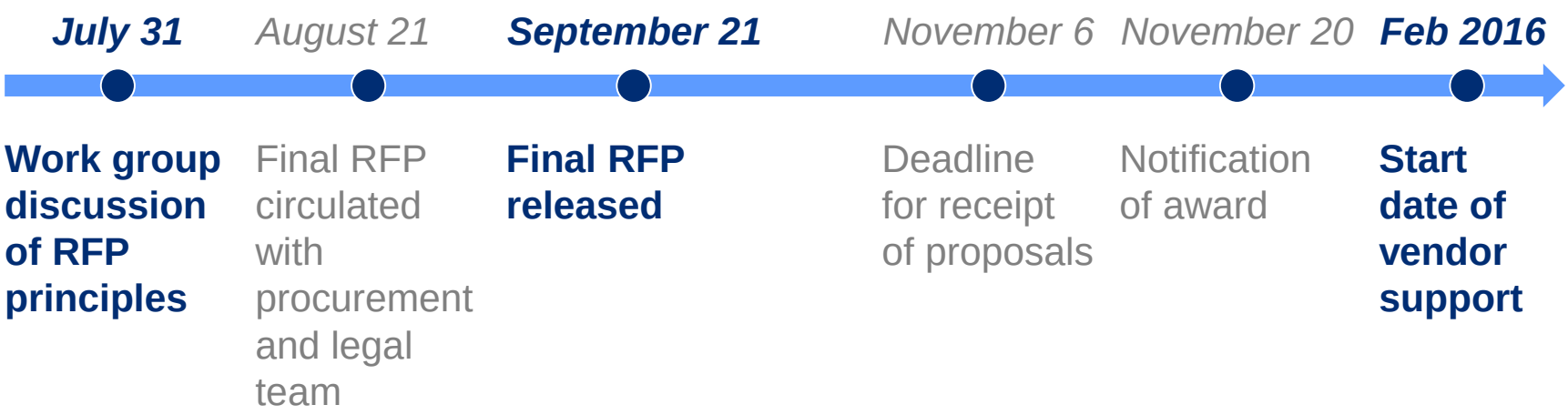
APC practices

- Participates in alternative payment contracts with payers
- Actively uses an EMR connected to local RHIOs
- Practices in a team-based care model that improves quality while lowering cost

Success requires a context in which practices payers are committed to alternative payment contracts and infrastructure investments

Practice transformation vendors will be procured through a competitive RFP to be released in September, with planned start by February 2016

Timeline for procurement of vendors



Practice transformation RFP will require decisions on five strategic domains

Domain	Components
1 Vendor scope of services	▪ Elements of support ▪ Mode of support (in-person, remote) ▪ Duration of support ▪ Vendor reporting
2 Vendor selection process	▪ Number of vendors ▪ Distribution of vendors regionally ▪ Criteria for selection
3 Provider participation requirements	▪ Provider participation eligibility criteria ▪ Milestone and participation requirements
4 Vendor payment and incentive structure	▪ Funds flow ▪ Payment types (variable, fixed) ▪ Incentive payments
5 Interaction with other initiatives	▪ Funding: DSRIP, TCPI, MAPCP, CPCi ▪ Public Health initiatives

1 A clear set of vendor requirements will ensure a consistent and effective product

Proposed scope of services for discussion / input

Elements of Support	▪ Pre-transformational assessment ▪ Tailored curriculum to individual practices and milestones ▪ Multi-practice collaboratives ▪ Semi-annual assessments ▪ Coaching
Mode of support	▪ Monthly in-person interactions ▪ Remote interactions, e.g. webinars, web resources or phone support
Duration of support	▪ 1 year per practice ▪ 3-year vendor contract, evaluated for continuation or cancelation each year
Vendor reporting requirements	▪ Initial assessment of practices ▪ Monthly practice progress reports, including an assessment of participation and progress towards APC milestones

Questions:

- How standardized should the curriculum be beyond milestones?
- How long should vendor contract last for?
- Should vendors be responsible for practice recruitment?
- How should vendors address population health goals?

2 The RFP should clarify criteria for selection of vendors

Proposed criteria for discussion / input

Distribution	▪ 1-4 vendors per region ▪ No maximum number statewide
Selection criteria	▪ Previous experience in Practice Transformation ▪ Operating model ▪ Ramp-up plan

Questions:

- Should there be a maximum number on vendors in a region? In the State?
- Can provider organizations serve as vendors?
- Should there be a minimum number of practices that vendors should serve?

3 Pre-APC Practices will be eligible for support but will require active participation

Proposed participating requirements for discussion / input

Provider Eligibility

- **Eligible:** Pre-APC practices only
- **Ineligible:** Practices receiving federal practice transformation, e.g. MAPCP, CPCi, TCPI

Provider Responsibilities

- Designated change agent within the practice
- Progress toward APC milestones
- Participation in vendors' activities and multi-practice learning collaboratives

Questions:

- Are there other eligibility criteria that should be considered?
- Who would determine eligibility?
- How should progress and participation be measured?

4 NYS would fund vendor support directly through a mixed payment model designed to support performance

Proposed vendor payment model for discussion / input

State

Fixed startup amount for each regional vendor contract

+

Variable component based on the number of practices that vendors recruit

+

Incentive Payment based on practices achieving milestones, improvement on outcome measures or enrolling in VBP

Vendors

Practice Support

Practices

Questions:

- What is the right payment structure to maximize effectiveness and efficiency?
- What variables should be used to determine incentive payments?

Appendix

Measures Recap: Purpose

- Measures should fit purpose(s)
- Purpose(s) include:
  - Evaluate patient experience, clinical quality, and avoidable costs in a consistent way across payers
  - Use for ‘value-based’ payments

Measures Recap: Goals

- Should strive towards alignment and parsimony
  - Alignment = same measures across payers
  - Alignment = measures that serve multiple purposes within APC, and without
- Avoid completely new measures
- Mix of process and outcome
  - Process measures should be closely associated with improved outcomes

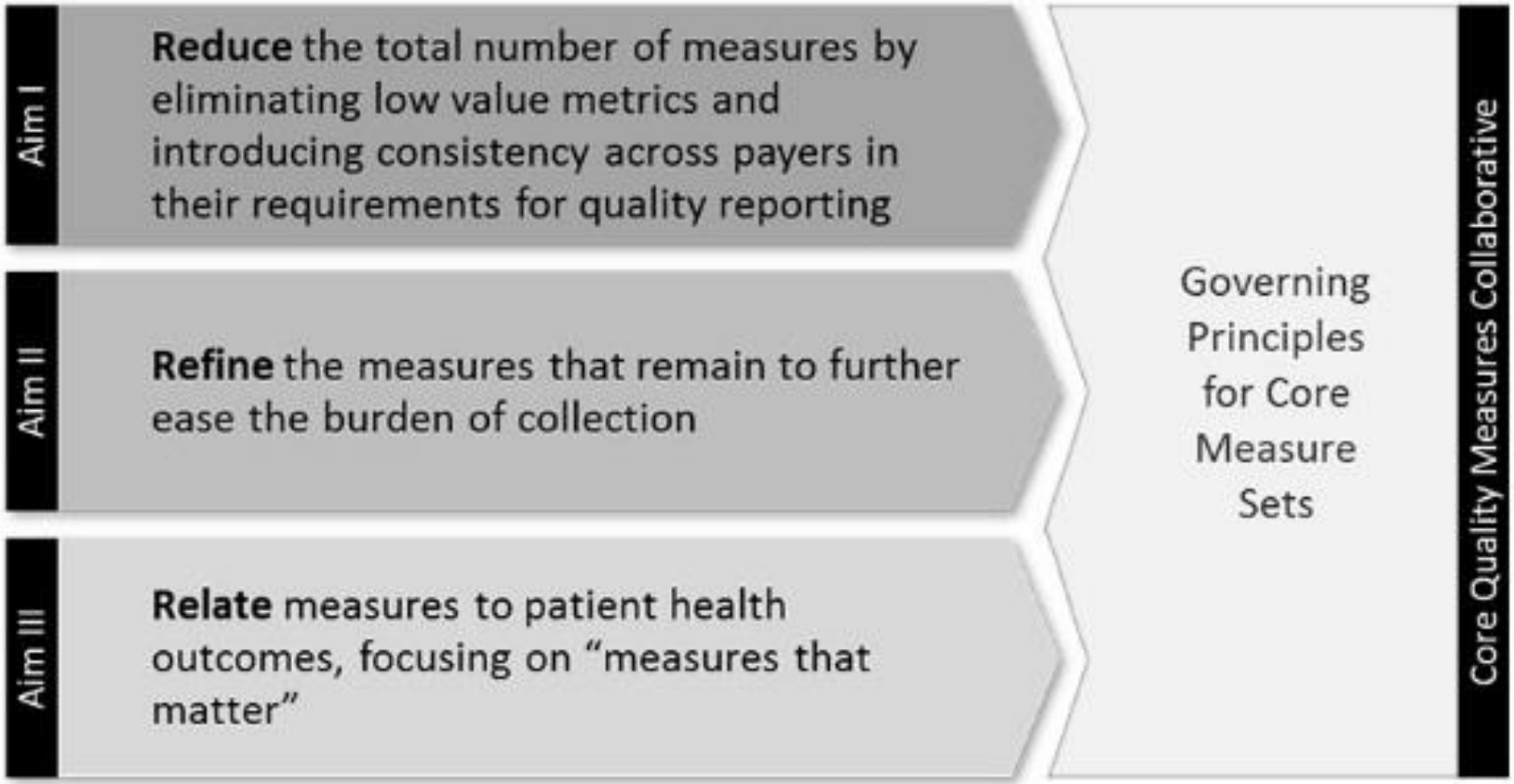
Measures Recap: Choice Considerations

- Alignment
- Fits Purpose(s)
- Opportunity
  - To meaningfully improve health
  - Influenced by health care providers/system
- Practical (lowest burden)
  - Data exists
  - Relatively easy to ‘mine’
  - Sufficient denominators
- Overuse and underuse

Measures Recap: Choice Considerations

- Reliable/Valid/Tested
  - NQF/NCQA/AMA-PCPI
- Relevant across population(s)
- Clinical quality measures includes:
  - Acute
  - Prevention
  - Chronic
- Mix: administrative, clinical/EHR, survey
- Meaningful to:
  - Patients
  - Payers
  - Providers

Core Quality Measures Collaborative 3Rs — Reduce, Refine, and Relate



Source: http://healthaffairs.org/blog/2015/06/23/the-core-quality-measures-collaborative-a-rationale-and-framework-for-public-private-quality-measure-alignment/

Measure Set Changes

- Completed/corrected DSRIP column
- Added column for Medicare Advantage
- Removed Asthma Ratio
- Add HEDIS Substance use
- Change Collab Care to Depression Screening and Follow-up

Measure Set Fit to Criteria

Alignment with other measurement programs:

- NQF endorsed: 16/19
- EMR Specs: 13/16
- QARR:14/16
- DSRIP:12/19

Note: # DSRIP projects focused on tobacco (27), flu immunizations (26), depression (42) and 3 utilization measures (99).

- MU:15/16
- MSSP: 10/19
- PQRS: 15/19
- CPC or MAPCP: 12/16

Ease of collection:

- Claims only: 8
- Hybrid (Claims and MR): 8
- Survey:2
- MR: 1

Balance: Age groups

- All: 7 ; Adults only: 7; Adult/Adolescents: 3; Child/Adolescents:1; Child only: 2

Balance: Type of Care

- Prevention:5
- Chronic disease prevention and management:5
- BH/Substance Abuse:2
- Patient reported:2
- Appropriate Utilization:6

Opportunity: Performance trends

- No change: 7
- Worst: 6
- Improved: 4 (3 utilization)
- Below goals (DSRIP): All
- Below national benchmark: 3/4

APC Milestones should provide a clear, achievable path for pre-APC practices interested in meeting APC standards

Pre-APC tier

Starting point for transformation support

APC Milestones

Clear signposts over time that are

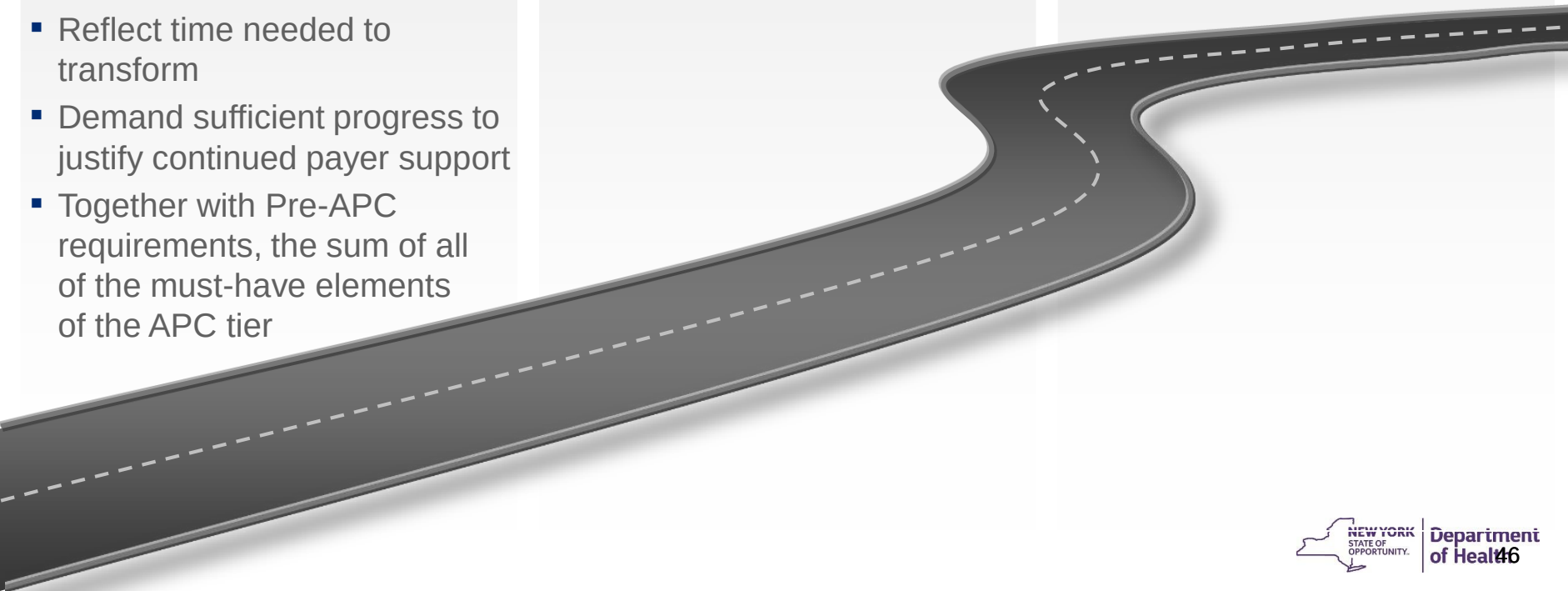
- Measurable and verifiable
- Reflect time needed to transform
- Demand sufficient progress to justify continued payer support
- Together with Pre-APC requirements, the sum of all of the must-have elements of the APC tier

APC tier

Key infrastructure in place for management of complex populations, with ability to succeed in upside risk settings

Premium APC tier

Practices manage population health integration including behavioral health, with ability to undertake upside and downside risk



Case examples: many multi-payer initiatives agree to provide monthly payments for support transformation contingent on milestones

Program[1]	Structural eligibility requirements	PMPM for milestones	Level of PMPM payments	Time PMPM payments start
Arkansas SIM	▪ Primary care office with # of beneficiaries only	✓	▪ Medicaid: $1-30 depending on risk ▪ Others: varies	▪ Enrollment
Delaware SIM	▪ Primary care office with # of beneficiaries only	✓	▪ TBD	▪ After meeting some milestones (max 1 yr)
Rhode Island CCSI	▪ Nurse care managers employed ▪ EHR meeting meaningful use	✓	▪ Payers in agreement: $4.50-6.00	▪ Enrollment
CPCI	▪ EHR meeting meaningful use	✓	▪ Medicare (avg, risk-adjusted): $20 (yrs 1,2), $15 (yrs 3,4) ▪ Participating payers: varies	▪ Enrollment

1 Details of milestones and payment models in appendix

Source: Expert interviews, State and CPCI websites

Case example: Arkansas has similar measures spread over 24 months

	3 months	6 months	12 months	18 months	24 months
Patient access		▪ 24/7 access by phone to panel members ▪ Track same-day appointment requests	▪ Short survey related to beneficiaries' ability to receive timely care and specialist access including behavioral health		
Care coordination and mgmt., population health	▪ Identify top 10% high-priority beneficiaries	▪ Develop strategies for care coordination and practice transformation, ▪ Address neighborhood barriers to care coord. ▪ Establish processes to contact patients in need of preventive care	▪ Implement process for contacting pts needing preventive care		
Operations / HIT		▪ Assess operations and opportunities to improve practice	▪ Invest in health care technologies and tools that support PT ▪ Join HIE and access pt discharge and transfer information	▪ Incorporate e-prescribing into practice workflows	▪ Use EHR for care coordination (including care plans)

Source: Arkansas Practice Transformation RFP

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Case example: Delaware simplified NCQA measures into milestones over time

	6 months	12 months	18 months	24 months
Patient access	▪ Same day-appointments and/or after-hours access to care	▪ 24/7 access by phone to panel members		
Care coordination / mgmt	▪ Identify the 5% of panel at highest risk and highest priority for care coordination ▪ Implement process for following-up after hospital discharge	▪ Document plan for launching multi-disciplinary team-based care plan for highest-risk pts ▪ Document plan to reduce ED overutilization	▪ Implement process for contacting patients needing preventive care	▪ Implement multi-disciplinary team-based care plan for high-risk patients ▪ Document plan for patients with behavioral health needs
Payment		▪ Care coordination fees start after meeting 12-month milestones		▪ Over longer term, plan to shift toward outcomes-based payments

Source: Delaware Consensus Statement on Primary Care Practice Transformation, May 2015

Case Example: Rhode Island's Multi-payer Compact agrees on specific PMPM payments for meeting performance targets

	Components	Year 1 (Startup)	Year 2 (Transition)	Year 3 (Performance Evaluation Year 1)	Year 4 (Performance Evaluation Year 2)
Structural requirements	NCQA achievement	Level 1	Level 2	Level 3	Level 3
	Nurse care managers employed	Requirements to receive any payments			
	EMR meeting meaningful use				
PMPM Payment based on number of Targets[1] Achieved	0-1	$4.50	$5.50	$5.00	$5.00
	2	$4.50	$5.50	$5.50	$5.50
	3	$4.50	$5.50	$6.00	$6.00

A $0.50 increase for a 2-3 PCP practice is $2-3,000[2]

- Would an example like this be feasible in NY?
- What other components would be necessary to generate consensus across the state?

1 Targets on process improvements, quality and patient experience, and utilization metrics; details in Appendix
2 Assuming each PCP carries a 2,000 patient panel

Source: Rhode Island chronic care sustainability initiative agreement

NEW YORK STATE OF OPPORTUNITY. Department of Health

Rhode Island Performance Targets

Target 1: Structural improvements (Practice Metric)	▪ Hire a nurse care manager; establish a compact with 4 specialists including a hospitalist to improve patient care; establish a plan/policy for after-hours care; have an electronic medical record and achieve level 1 meaningful use; comply with the Quality Partners of Rhode Island Hospital and community physician best practices; demonstrate best practices for outpatient transitions of care; demonstrate use of evidence-based care; submit quality data
Target 2: Clinical process measures (Provider Metric)	▪ Achieve benchmark goals on specified CAHPS survey items; meet benchmark goal or achieve 50 percent improvement on at least 4 of 7 metrics; Diabetes HbA1C<8, Diabetes BP<140/90, Diabetes LDL <100, Hypertension <140/90, Tobacco Cessation, Adult BMI (18-64), Adult BMI (65+)
Target 3: Outcome measures (Provider Metric)	▪ CSI practices, in aggregate, to reduce emergency department and all-cause inpatient hospital admission rates by 7.5% and 5% respectively, relative to a comparison group

Source: Rhode Island chronic care sustainability initiative agreement, 2013

Case example: CPCI follows a detailed 3-year timeline (1/2)

Milestone	Year 1	Year 2	Year 3
1. Budget	▪ Annual budget or forecast with anticipated CPCI expenses and flows	▪ Annotated annual budget forecast with projected new CPC Initiative practice	▪ Record actual CPC expenditures from Prev. year 2 and Complete an annotated annual budget
2. Care Management for High Risk Patients	▪ Provide information about care management of high risk patients	▪ Maintain at least 95% empanelment to provider and care teams ▪ Continue to risk stratify all patients; ▪ Provide care management to at least 80% of highest risk patients	▪ Continue to risk stratify all patients; Provide care management resources
3. Access and Continuity	▪ 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice's medical record	▪ Enhance access by implementing at least one asynchronous form of communication	
4. Patient Experience	▪ Assess and improve patient experience	▪ Conduct surveys and/or meetings with a Patient and Family Advisory Council (PFAC)	
5. Quality Improvement	▪ Generate and review practice- or provider-based reports with a minimum of one quality measure and one utilization measure	▪ Report the EHR clinical quality measures	▪ Continue to perform continuous quality improvement using EHR CQM data

Source: CMS.gov

Case example: CPCI follows a detailed 3-year timeline (2/2)

Milestone	Year 1	Year 2	Year 3
6. Care Coordination across the Medical Neighborhood	▪ Demonstrate active engagement and care coordination by selecting and reporting on care coordination measures	▪ Describe activities undertaken to improve the results.	▪ Contact at least 75% of patients ▪ Maintain or enact care compacts/collaborative agreements
7. Shared Decision making	▪ Identify a priority condition, decision, or test that would benefit from shared decision making and the use of a decision aid	▪ Implement shared decision making tools or aids; Generate a metric for the proportion of patients who received the decision aid	▪ Use at least three decision aids to support shared decision making in preference sensitive care. ▪ Track use of the aids
8. Participate in learning Collaborative	▪ Participate in the market-based learning collaborative and share knowledge, tools, and expertise through attendance at three face-to-face meetings annually and in web-based meetings at least monthly	▪ Participate in all three all-day CPC learning sessions in your region. ▪ Participate in one learning webinar per month.	▪ Fully engage and cooperate with the Regional Learning Faculty
9. Health Information Technology	▪ Stage I meaningful use		▪ Stage II meaningful use

Source: CMS.gov

Case example: TCPI uses five phases to track practice transformation

	Phase 1: Setting aims and developing basic capabilities	Phase 2: Reporting & using data to Generate improvements	Phase 3: Achieving aims of lower costs, better care, and better health	Phase 4: Getting to benchmark status	Phase 5: Practice has demonstrated capability to generate better care, better health at lower cost.
Operations	▪ Submit a Detailed Plan ▪ Perform self-Assessment and create baseline ▪ Start Training for at least 50% of staff		▪ Optimizing reports to drive clinical practice improvement on a monthly basis ▪ Sets clear expectations to optimize efficiency, outcomes, and accountability		▪ Practice has developed business acumen for the various types of alternative payment models
QI / Pop Health	▪ Establish measures, plans and mechanisms for addressing the needs of their patients/families	▪ Practice provides care management to at least 50% of highest risk patients	▪ Reduced unnecessary tests and hospitalizations by at least 25%	▪ Practices submit utilization reports to PTN on a monthly basis ▪ Continuously makes clinical improvement changes	▪ Practice sustains prior improvements in key metrics for at least one year
Care coordination		▪ Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, and billing data to drive clinical practice improvement	▪ Tracks, supports and follows up with patients ▪ Has a formal written vision related to care coordination	▪ Practice tracks patients, on a monthly basis ▪ Process in place to link the patient to a care provider and care team	

Source: CMS.gov