NEW YORK STATE OF OPPORTUNITY. Department of Health

Integrated Care Workgroup

Meeting #10

Discussion document

November 16, 2015

Agenda – November 16, 2015

Timing	Topic	Lead
10:00-10:30am	Welcome / updates to existing model	Foster Gesten / Susan Stuard
10:30-12:00pm	Medicaid alignment with APC	Marc Berg
12:00-12:15pm	Working lunch	
12:15-1:00pm	Practice Transformation Technical Assistance (including oversight /TCPI alignment)	Hope Plavin / Tom Mahoney / David Nuzum
1:00-1:30pm	Performance measurement and reporting	Anne-Marie Audet
1:30-1:50pm	Updates on stakeholder engagement	John Powell / NEBGH
1:50-2:00pm	Closing and next steps	Foster Gesten / Susan Stuard

Contents

Welcome / updates to existing model: goals

Purpose: Review timelines and current APC model

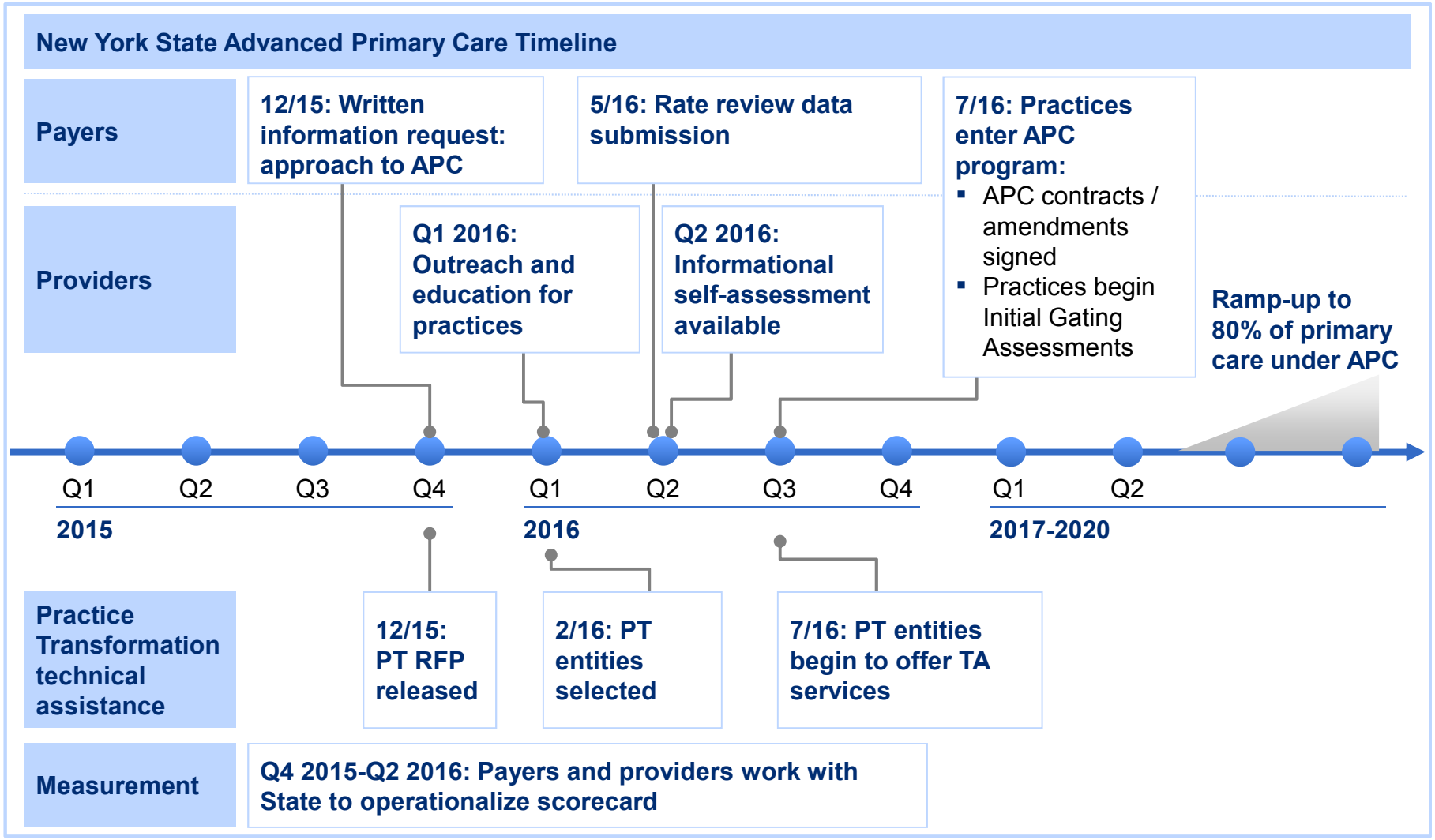
For information

- Proposed timeline for implementation
- Principles for making improvements to the APC model going forward
- Improvements to the model based on stakeholder feedback
- Plan for behavioral health within APC

For workgroup input

- What major design issues remain before the model is finalized for Year 1 (2016)?
- Does the model describe appropriate progress on behavioral health, given that the Collaborative Care Model component of APC will be developed later?

Timelines for payers, providers, and TA are designed to support launch in July 2016



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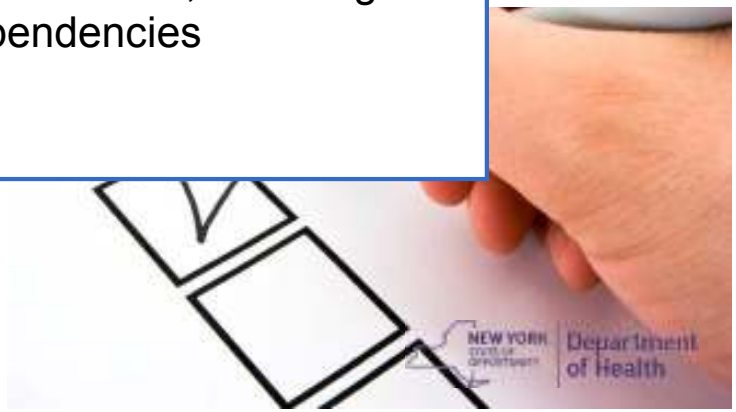
Principles for changes to APC model

The APC model is maturing through input from the working group, payers, and providers

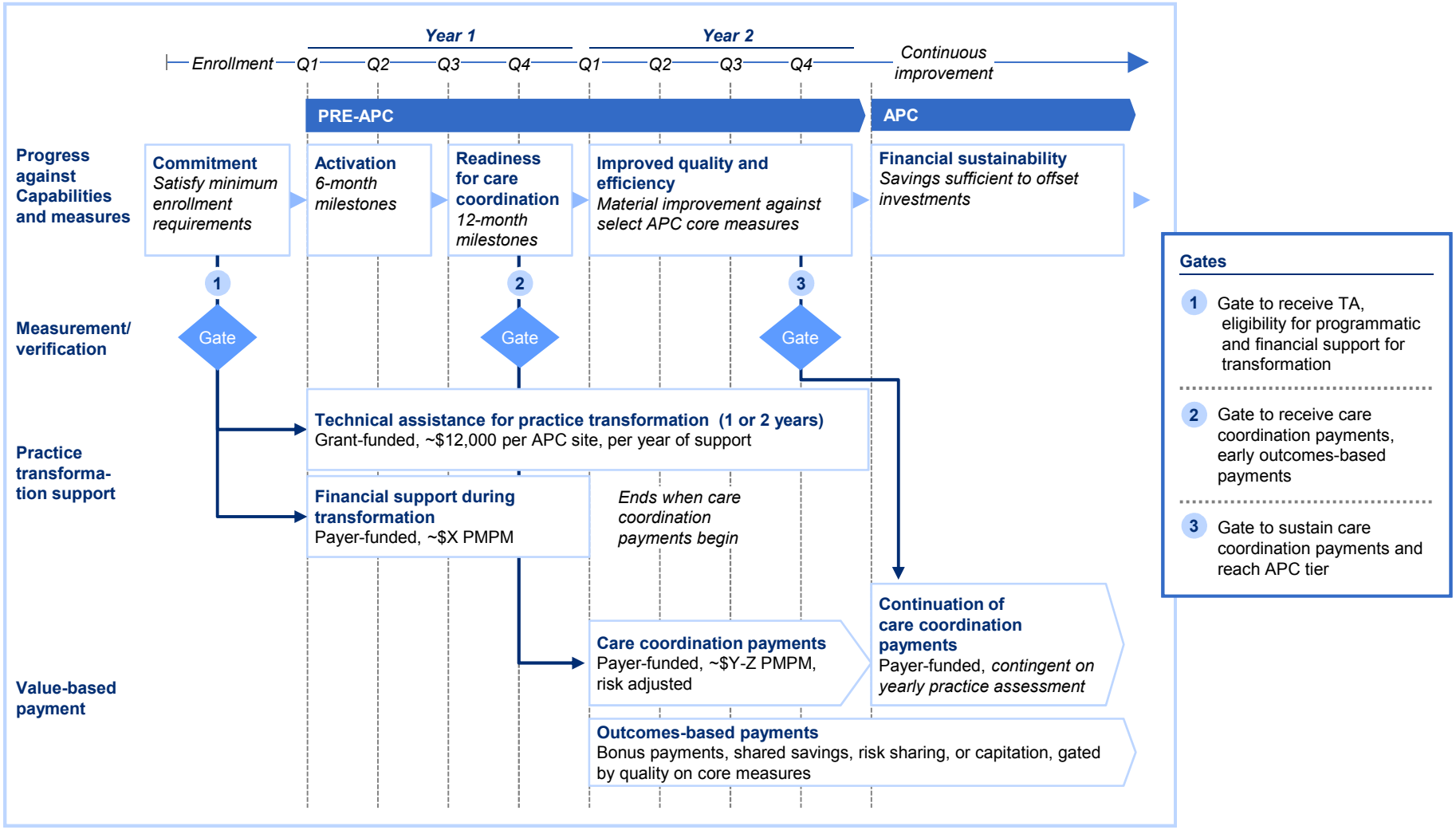
- Current model represents almost a year of multi-stakeholder input and consideration
- Each piece of the model has been considered the context of the whole: proposed structural changes are tied to performance (not just activities), and supported by alternative payments

Going forward, proposed changes will be considered if they are:

- Specifically implementable
- Linked to a value proposition (balanced against necessary investments) supported by providers, consumers and payers for all practices statewide
- Compatible with other elements of the APC model, including interdependencies



Review: Path to APC over time for practices starting out



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Updated: Practice-wide structural Milestones

Updates since WG

	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet* Prior milestones, plus …	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination* Prior milestones, plus …
Participation	▪ Early change plan based on self-assessment tool ▪ Designated change agent / champion ▪ Participation in TA Entity APC orientation ▪ Commitment to achieve gate 2 milestones in 1 year	▪ Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	▪ Process for Advanced Directive discussions with all patients	▪ Plan for patient engagement and integration into workflows within one year	▪ Engagement: survey, focus group, advisory council or equivalent, plus QI plan based on results (yearly)
Population health			▪ Participate in bimonthly Prevention Agenda calls ▪ Annual identification and reach-out to patients due for preventative or chronic care mgmt ▪ Process to refer to self-management programs
Care Management/ Coord.		▪ Tracking system to identify highest risk patients for CM/ CC ▪ Ramp-up plan to deliver CM / CC to highest-risk patients within one year ▪ Behavioral health: evidence-based process for screening, treatment where appropriate[1], and referral	▪ Care plans developed in concert with patient preferences and goals ▪ CM delivered to highest-risk patients ▪ Referral tracking system ▪ Care compacts or collaborative agreements for timely consultations with medical specialists and institutions ▪ IMPACT model for depression care ▪ Post-discharge follow-up process
Access to care	▪ 24/7 access to a provider (synchronous and asynchronous communication with explicit response time goals)	▪ Same-day appointments ▪ Culturally and linguistically appropriate services	▪ At least 1 session weekly during non-traditional hours
HIT	▪ Plan for achieving Gate 2 milestones within one year ▪ E-prescribing	▪ Tools for quality measurement encompassing all core measures ▪ Tools for community care coordination including care planning, secure messaging ▪ Attestation to connect to HIE in 1 year	▪ 24/7 remote EHR access ▪ Secure electronic provider-patient messaging ▪ Meet current Meaningful Use standards ▪ Connected to local HIE qualified entity and using data for patient care
Payment model	▪ Commitment to APC-compatible contracts representing 60% of panel within 1 year	▪ APC-compatible contracts with payers representing 60% of panel	▪ APC-compatible contracts with payers representing 60% of panel ▪ Minimum upside risk-sharing

Measurement and performance milestones to follow

1 Uncomplicated, non-psychotic depression

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Review: Proposed measurement and performance Milestones

	Gate 1	Gate 2	Gate 3	
	Commitment *What a practice achieves on its own, before any TA or multi-payer financial support*	**Readiness for care coordination** *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet*	**Demonstrated APC capabilities** *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination*	**Yearly performance against core measures within APC**
Objective	Ensure practices can measure, report and engage with core measures in preparation for performance improvement			Ensure practices are using APC capabilities to drive improved performance
Proposed milestones	▪ **Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	▪ **Report and use data** on all core measures, including data necessary to assess health disparities ▪ **QI plan:** On at least one claims-based measure	▪ **QI plan:** on 3 prioritized core measures, including utilization and addressing health access and outcome disparities ▪ **Positive trajectory** on utilization/cost core measures while meeting quality expectations	▪ **Closure of gap** to agreed-upon benchmark on 3 core measures (including at least one utilization measure), while meeting yearly core measure quality expectations ▪ **Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

APC milestones incorporate the central role of behavioral health and allow for future modules centered on collaborative care

BH elements across APC gates

	Commitment Gate 1	Readiness for care coordination Gate 2	Demonstrated APC Capabilities Gate 3
Care Management / Coord.	▪ <none>	**Prior milestones, plus …** ▪ **Behavioral health: evidence-based process for screening, treatment where appropriate[1], and referral**	**Prior milestones, plus …** ▪ **Care compacts or collaborative agreements for timely consultations with medical specialists and institutions** ▪ **IMPACT model for depression care**

A future "Premium" APC incorporating Collaborative Care will have to address several questions:

- How will payers support the new programs?
- What are the implications of implementing Collaborative Care in different settings?
- Will this be bundled with other "Premium" features, or modular?

1 Uncomplicated, non-psychotic depression

Contents

Medicaid alignment with APC: goals

Purpose: Describe Medicaid's approach to APC

For information:

- Medicaid's approach to APC including:
  - Capabilities and performance expectations from Medicaid and DSRIP
  - Performance measurement
  - Support for practice transformation
  - Value-based payment options including a detailed look at primary care bundles

For workgroup input:

- What are the group's reactions to how Medicaid will approach APC?
- Given how Medicaid will approach APC, how are other payers thinking about designing their approach to APC?
- What additional considerations might Medicaid consider in designing VBP programs for primary care?

Medicaid and DSRIP programs are largely aligned with APC

- **Will Medicaid expect all Medicaid primary care practices to participate in APC?**
  - *PPSs PCPs must become 'PCMH (NCQA 2014) or APC'. At this point participation in APC specifically is not required.*
- **Will all Medicaid primary care practices receiving the PCMH NCQA 'bump' be expected to eventually participate in APC in order to continue to receive the 'bump'?**
  - *The PCMH NCQA 'bump' today has no conditions for performance, but in the future these practices will likely have a performance requirement. Consistent with APC, this may take the form of successfully passing Gate 3 within one year and meeting performance requirements, otherwise the PCMH NCQA 'bump' will cease.*
- **How will Medicaid measure performance in primary care?**
  - *Medicaid primary care practices will increasingly be measured using the APC core measure set. For those practices involved in chronic bundles, there will also be bundle-specific measures.*
- **How will Medicaid support practice transformation?**
  - *Medicaid primary care practices part of PPSs will receive DSRIP payments to support their transformation toward NCQA (which earns them APC Gate 2) or toward their transformation to APC Gate 2 without NCQA.*
- **What kind of outcomes-based payments will be available for primary care?**
  - *Medicaid primary care practices will have flexibility to choose from the VBP roadmap (Level 1 and above), including the option of doing chronic bundles or a professional-led ACO. Being an PCMH NCQA or APC will not be a requirement for entering VBP arrangements.*

Content

1. Introduction to Value Based Payment in NYS Medicaid
2. Alignment of VBP for Primary Care in Medicaid with the APC Model and the activities of the Integrated Care Workgroup
3. Contracting Primary Care

Introduction to VBP

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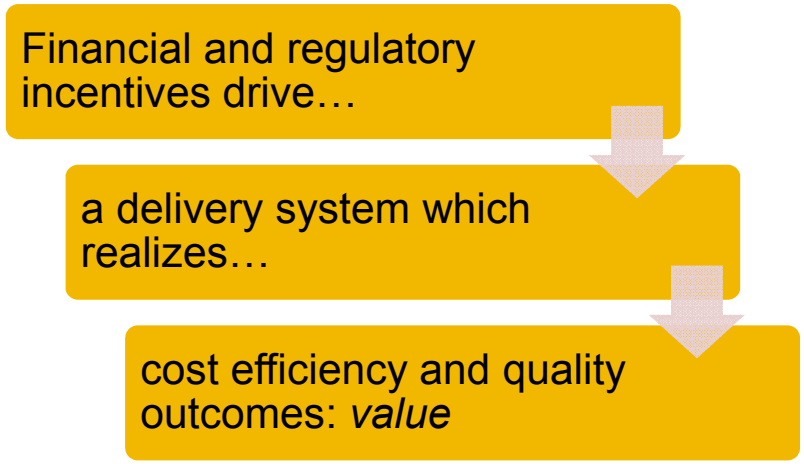
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration



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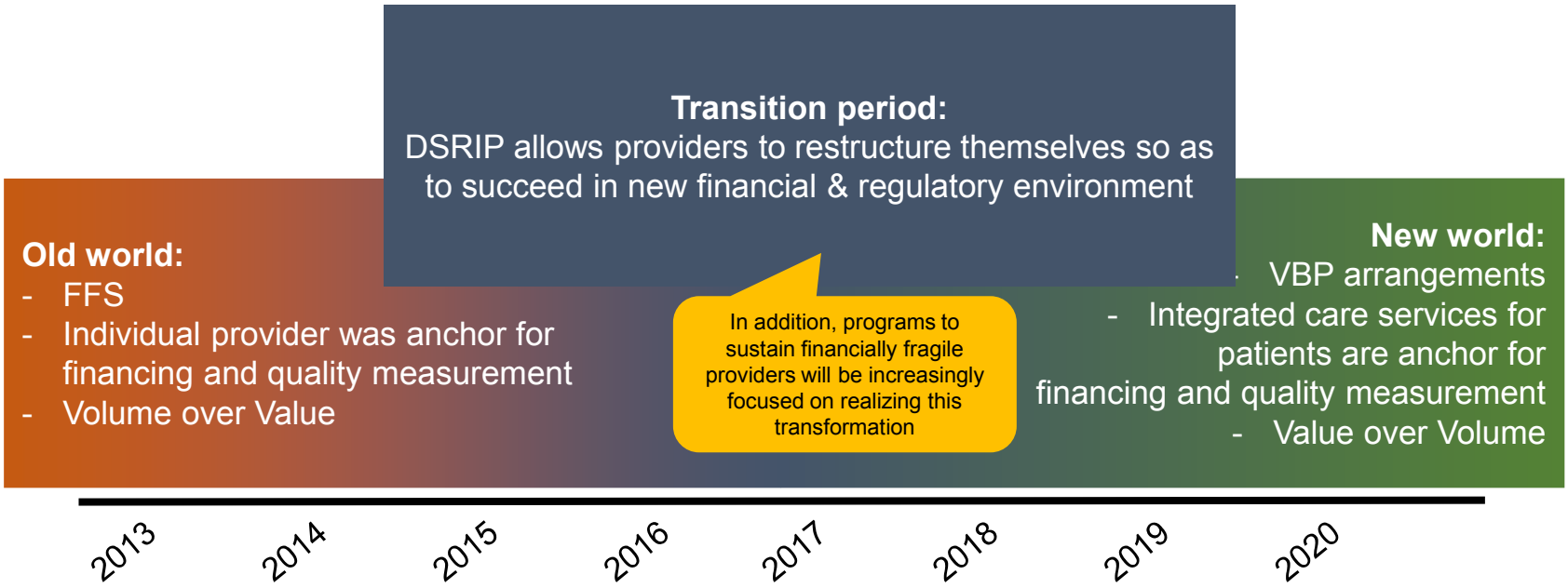
The DSRIP Challenge – Transforming the Payment System



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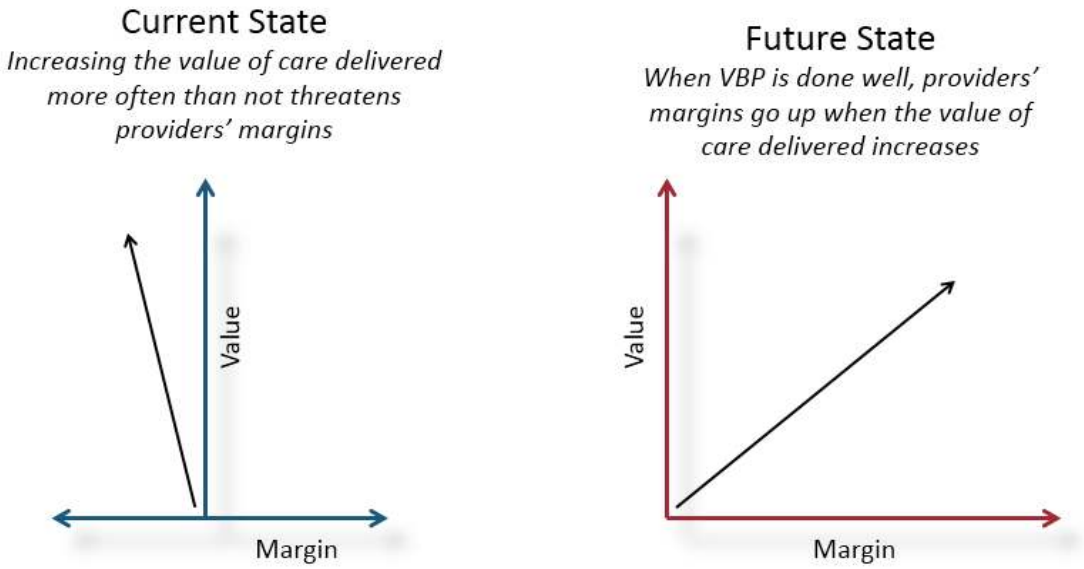
A new business model

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***



Goal – Pay for Value not Volume

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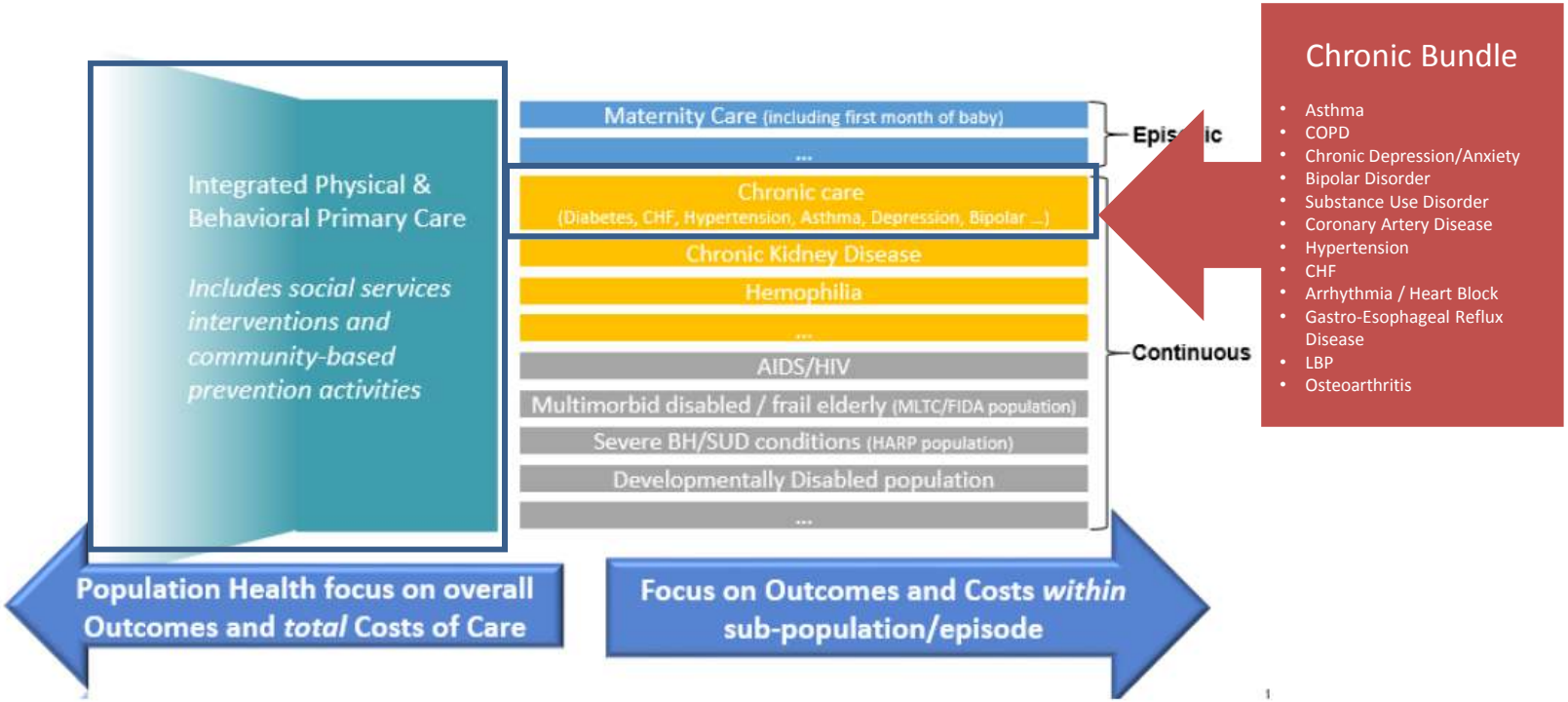
The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function



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The Path Towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and providers can jointly choose from.

Providers and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of a health system (hospital and/or physician led) – ACO model
- Per integrated service for specific condition (acute or chronic episodes): maternity care; diabetes care
- For Integrated Primary Care (usually including the Chronic Bundle)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities; MLTC

Providers that contract one of these VBP Arrangements are called 'VBP Contractors'. These can be individual providers, IPAs or Medicaid ACOs.

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- Per integra… es care
- For Integra…
- For the tota… health needs and comorb…

The Roadmap has been created with very broad stakeholder support and has been approved by CMS.

Currently, some 17 committees and Clinical Advisory Groups are filling in details, involving over 450 stakeholders throughout the State

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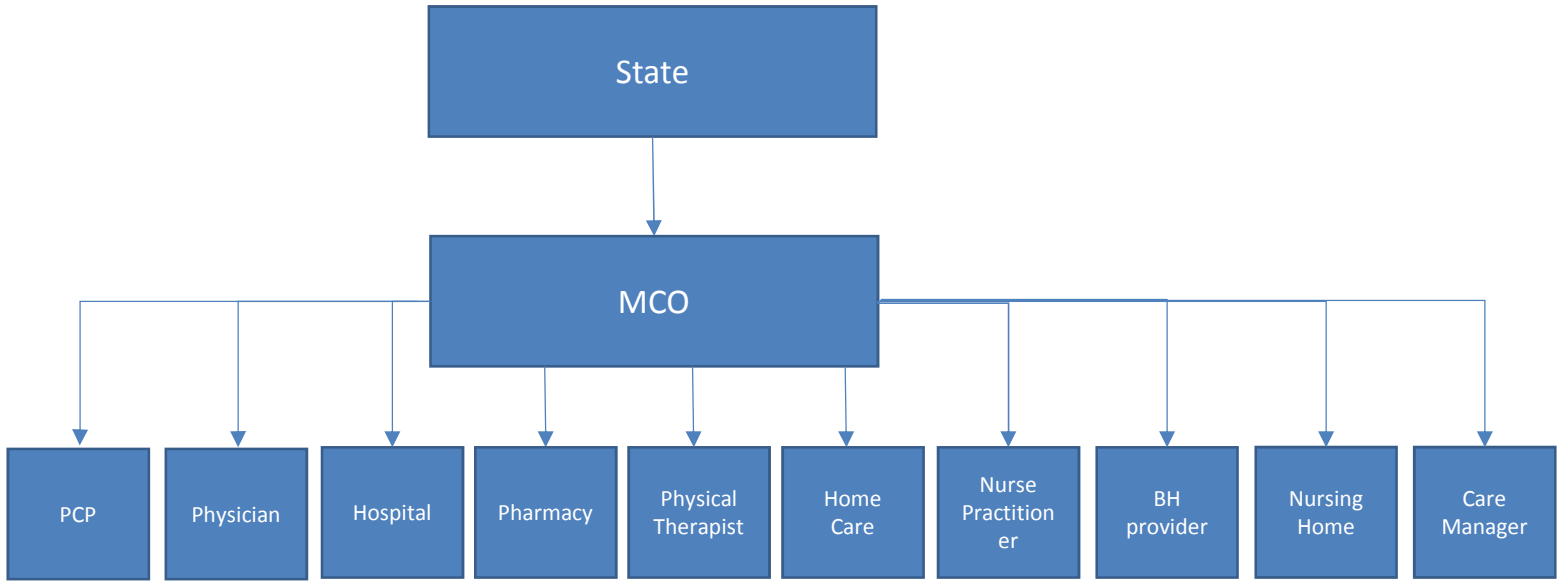
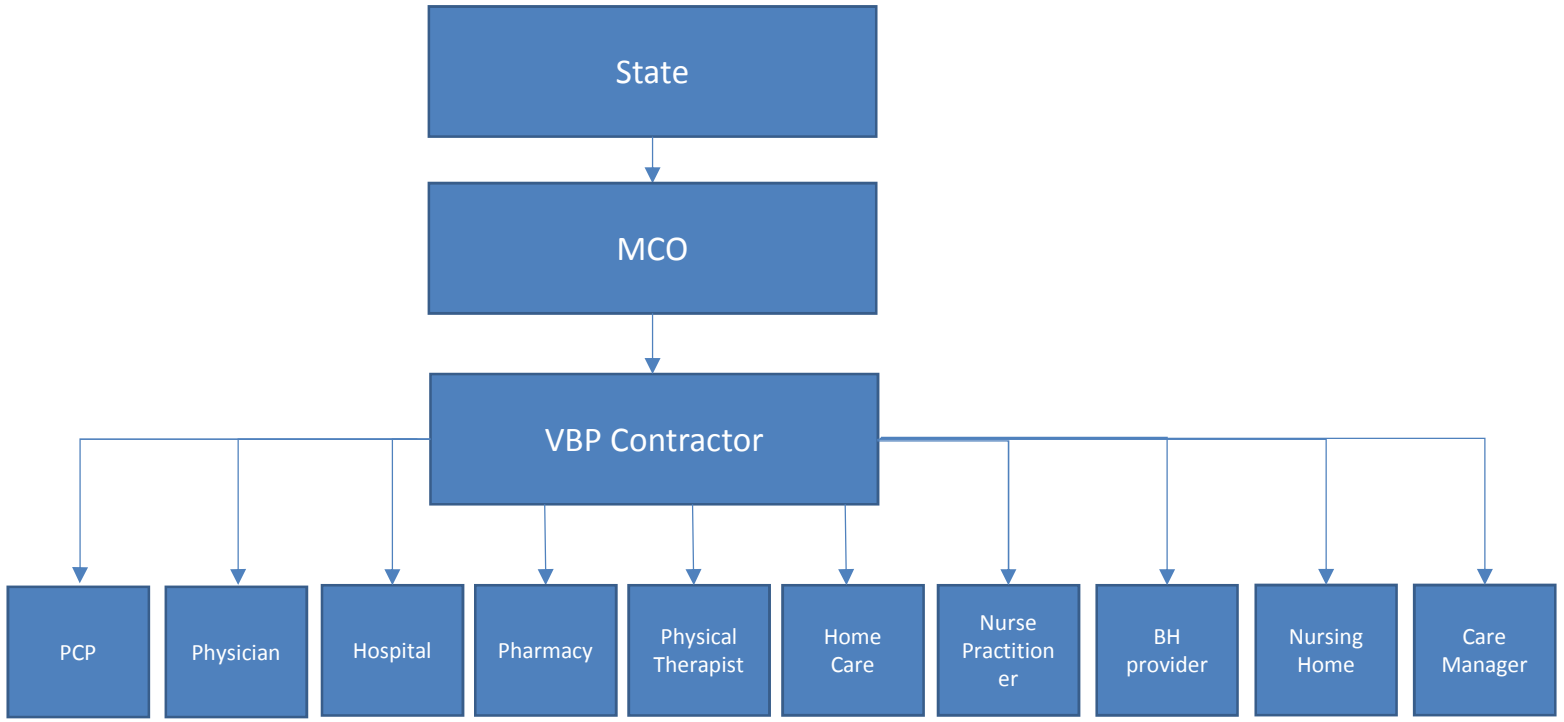
Current Medicaid Funds Flow



Future Medicaid Funds Flow



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MCOs and VBP contractors can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and providers can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
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)	PMPM or prospective payment for episode(s) (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5

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Alignment of VBP for Primary Care in Medicaid with the APC Model and the activities of the Integrated Care Workgroup

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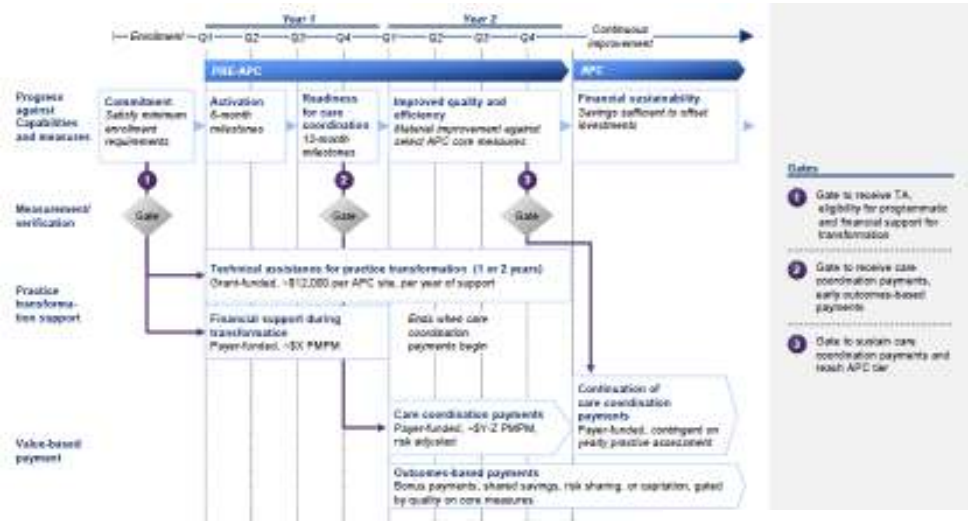
How does VBP in Medicaid align with the transition to APC?

- DSRIP: PPSs receive funds to support Primary Care Practices to meet PCMH (NCQA 2014) or APC (SHIP) standards
- Achieving these standards is vital to amount of DSRIP payments the PPSs receive
- Achieving PCMH (NCQA 2014) status qualifies as Gate 2 in the pre-APC phase
- *The further in the progress towards APC status, the further a primary care practitioner will be ready to engage in Value Based Payment*



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How does VBP in Medicaid align with the transition to APC?

- The default assumption that the Integrated Primary Care VBP Arrangement includes the care for both physical and behavioral chronic health conditions
- A strong focus on population health
- Increasing responsibility for reducing 'downstream' costs:
  - Avoidable ER visits & hospital admissions
  - Potentially avoidable exacerbations & complications
  - Avoiding readmissions by actively coordinating post-acute care
  - Reducing overall care costs through population health
  - …
- APC quality measures will be adapted
  - These become standard for MCO-Integrated Primary Care contracting
  - For the chronic conditions, additional measures will be in place

Chronic Bundle

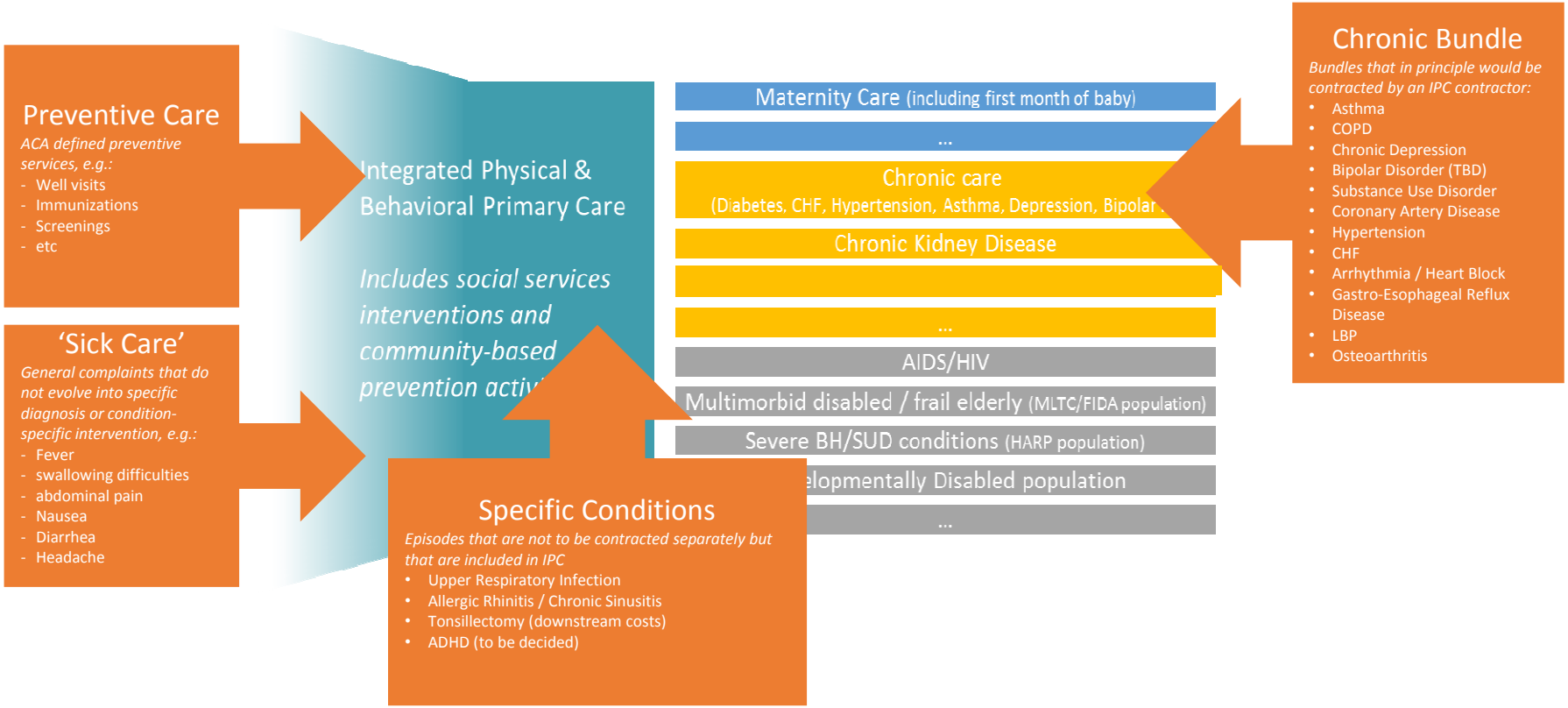
- Asthma
- COPD
- Chronic Depression/Anxiety
- Bipolar Disorder
- Substance Use Disorder
- Coronary Artery Disease
- Hypertension
- CHF
- Arrhythmia / Heart Block
- Gastro-Esophageal Reflux Disease
- LBP
- Osteoarthritis

How does VBP in Medicaid align with the transition to APC?

- 'Pay for performance' will move from paying for structure and process (i.e., payment for achieving PCMH status) to being rewarded for lowering downstream costs through improving population and patient outcomes

- The State will not demand a certain PCMH or APC level to enter into a Level 1 or higher VBP arrangement
  - For PCPs to enter into a up- and downside VBP arrangement, MCOs may require a minimum level of organizational maturity

Integrated Primary Care (IPC) Definition in Medicaid aligns with APC definition: *what is included?*



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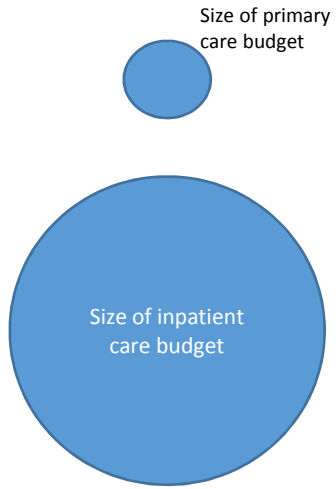
Options to reduce downstream costs
and realize significant shared savings

- Reduce avoidable ER visits & hospital admissions
- Reduce potentially avoidable exacerbations & complications
- Avoiding readmissions by actively coordinating post-acute care
- Reducing overall care costs through population health
- Rationalizing drug utilization
- Optimizing utilization of high cost imaging
- Avoiding low-value interventions:
  - Tonsillectomies
  - Tubes
  - Back surgery for generic low back pain
  - …



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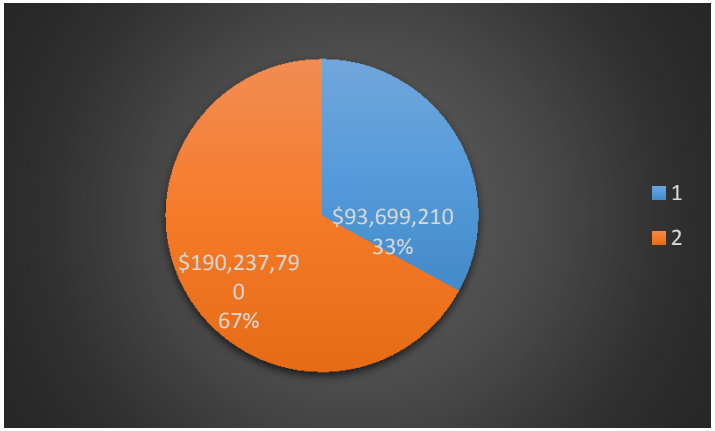
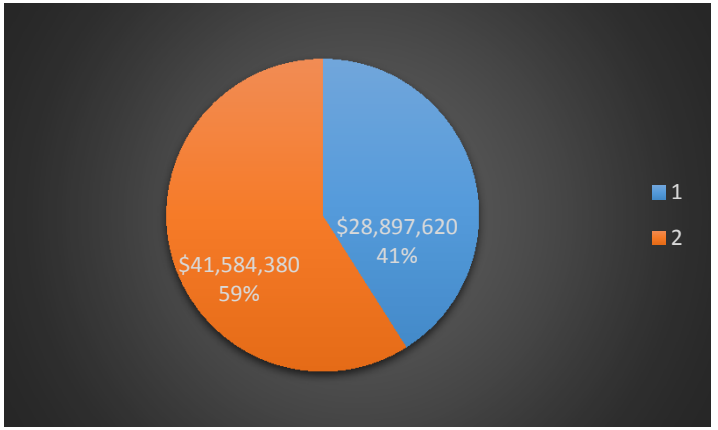
Costs for Potentially Avoidable Complications Represent $528M of All Asthma and COPD Costs

% Potentially Avoidable Complication Costs Relative to Total Costs of ASTHMA Episodes
Total ASTHMA spend: $284M



% Potentially Avoidable Complication Costs Relative to Total Costs of COPD Episodes
Total COPD spend: $70M



Source: 01/01/2012 – 12/31/2013 Medicaid claims. 100k beneficiaries (2%) have been excluded due to data quality issues. Data is annualized. Due to limits in current data cleansing, accuracy of information is limited. Duals excluded. Subpopulations (HIV/ADIS, HARP, DD, MLTC) are not included.

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Contracting Primary Care

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Integrated Primary Care

- As explained in the NYS VBP Roadmap, Integrated Primary Care does not *need* to be contracted as such:
  - It can remain outside of the VBP arrangements[1]
  - It can remain in a current 'pay for performance' arrangement (Level 0), which would not be recognized as VBP according to the Roadmap[1]
  - Primary care and the chronic bundle can be contracted by an ACO contracting Total Care for the Total Population.
  - In HARP, HIV/AIDS and MLTC, APC care is included in the total care for the total subpopulation VBP arrangement.

1. This would imply that it would not be counted as VBP and thus not count towards the State's goals of 80-90% .

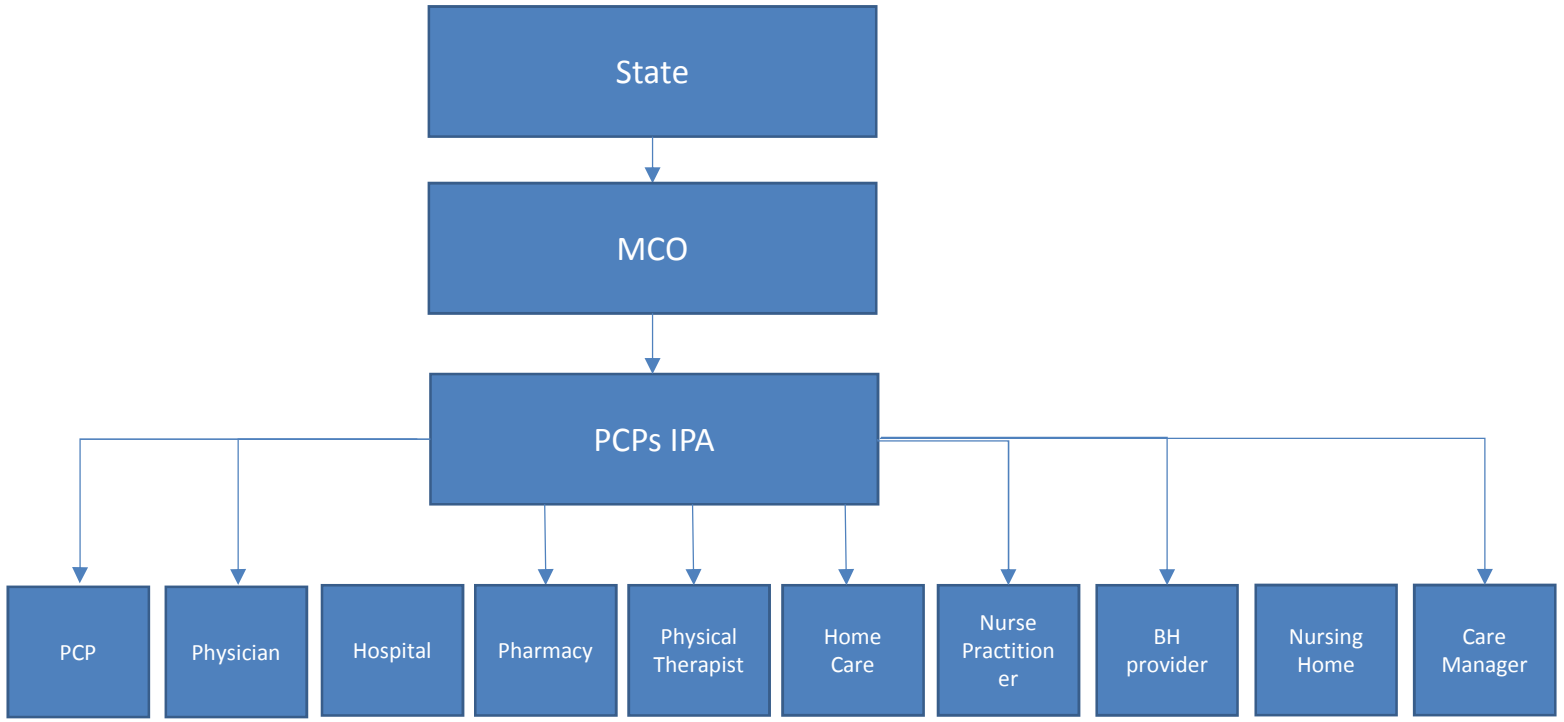
Contracting Integrated Primary Care – current state

Current modes of Contracting:	*Remarks:*
FFS (with or without shared savings)	Often combined with quality bonus/withhold
Partial or total capitation (PMPM), based on historical costs and/or with add-ons: - **Practice Transformation** - **Care Management**	
Bonus payments from associated hospitals who are at risk for total cost of care	A precursor for the kinds of arrangements that will typify VBP in the future

Contracting Integrated Primary Care – future state (Medicaid)

Future modes of Contracting:	*Remarks:*
FFS (no shared savings/risk) with or without quality bonus/withold	Not counted as VBP
FFS (shared savings/risk)	VBP Level 1 or 2
(Partial) capitation (PMPM) based on historical costs and/or with add-ons: **- Practice Transformation** **- Care Management** ***MCOs could link PMPM increases to progress through the APC gates***	VBP Level 2 or 3
Incentives from associated hospitals or other VBP contractors at risk for total cost of VBP arrangement	Over time, this may become more important than direct contract with MCOs (unless PCPs become VBP contractors themselves)

Possible contracting option



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The push for value

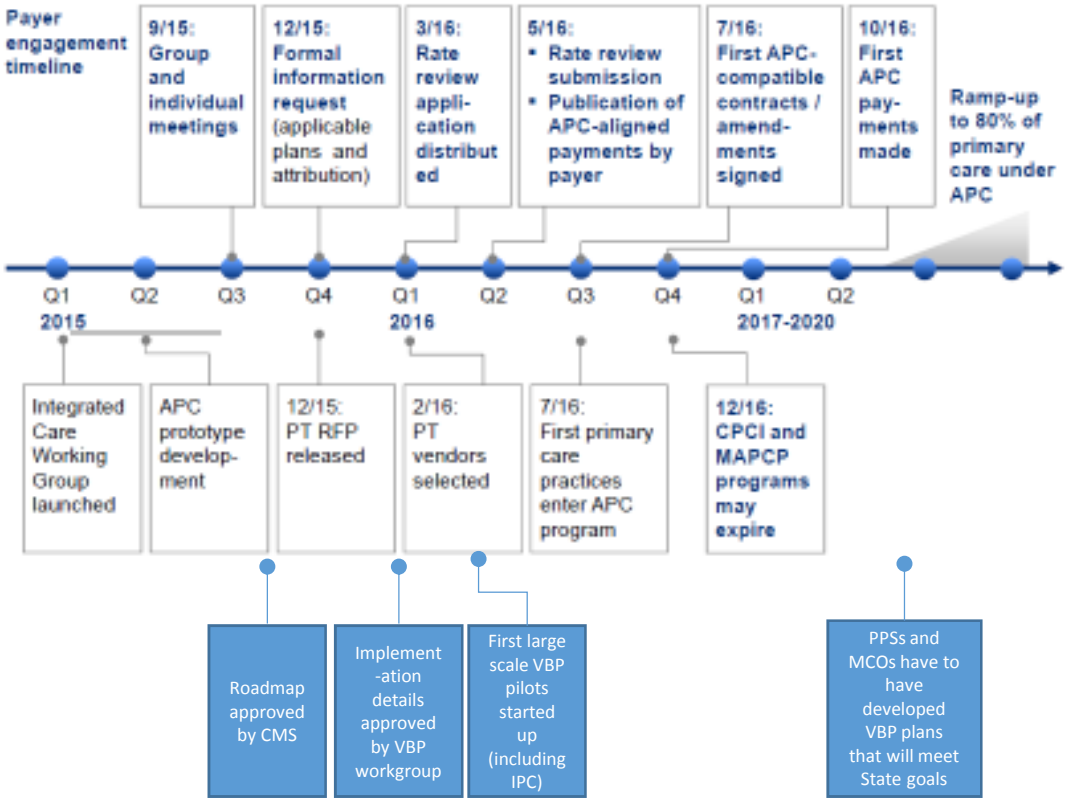
- VBP is as much about quality as it is about efficiency
- High value providers (high quality/low cost) may receive upward adjustments of their PMPM rates
- Low value providers (low value/high cost) may receive downward adjustments of their PMPM rates
- In addition, quality scores impact the amount of shared savings/losses received.

- *The State will set guidelines for how to do this, but the financial negotiations are left to the MCOs and the VBP contractors*

- *The payments from the State to the MCOs, however, will be determined by the value delivered by the plans on the different VBP arrangements – including IPC*

NYS Medicaid VBP and APC timeline

- APC
- Medicaid VBP



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Questions?

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Practice transformation technical assistance: goals

Purpose: Updates on the PT technical assistance, alignment with TCPI, and input on approach to transformation

For information:

- Comments from stakeholder meetings regarding needs for practice transformation
- Oversight needs and proposed approach
- Current efforts to coordinate between TCPI and SIM

For workgroup input:

- What else should the state consider to ensure effective technical assistance for practice transformation?
- How can working group members help with communications around options for PT TA in support of APC?

Sequence of events for SIM-funded practice transformation

Timeline of interactions between practices and TA Entities

Component	Description
Self-assessment	**Informational self-assessments** to engage practices in their needs and strengths, indicate the program (e.g., SIM, TCPI) each practice may be eligible for, and educate the practice to available TA Entities for PT TA
TA entity choice	**Practices choosing TA Entities** to assist them in practice transformation based on options in region and practice comparison of TA Entity services and curricula
3rd-party assessment	**On-site gating assessments** of practices, performed by TA Entities and audited by oversight entity, that can be used trigger applicable APC payments from all participating payers and verify TA needs of practices
TA plan and commitment	**TA Entities developing tailored curriculum plans** to practices and practices choosing whether to commit to the program, with an opportunity to change TA Entities
Ongoing PT TA	**Ongoing PT TA** including assessment and reporting of practice progress, auditing of TA Entity and practice performance
Repeat assessments as needed	**On-site gating assessments for Gates 2 and 3 as needed** by TA entity, subject to targeted and random auditing

What we heard: key design decisions around the practice transformation process

FOR DISCUSSION

What we heard	Design decision
▪ It is important to ensure a **clear message** across multiple statewide programs for PT TA	▪ TCPI and SIM will coordinate communications efforts and design a joint pre-assessment
▪ **Curricula should be coordinated** between TA Entities	▪ DOH will specify curriculum guidelines and facilitate a set of common resources for all entities ▪ DOH will publicize successful methods and develop means to share best practices
▪ TA Entities must be **capable of meeting the needs of diverse practices**	▪ TA Entities will be evaluated in part on ability to tailor methods and curriculum to different practice types ▪ TA Entities will be permitted to adjust staffing levels as needed
▪ Compensation must be structured in such a way to **ensure coverage of practices irrespective of size or initial gating**	▪ Practices will select TA Entities from a set of options designed to ensure coverage of all practices ▪ TA Entities will be compensated on a per-practice, not per-provider, basis according to time needed for support (depending on initial Gate)

RFP will be released in December

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What is the most appropriate oversight structure over the TA Entities?

Needs for oversight

- **A single source of truth for gate validation** for each practice statewide – triggering appropriate payments from participating payers
- **Oversight for TA Entities delivering transformation services** to practices across the state

Challenges

- TA entities may be best positioned to evaluate practices, but **Gate determination will need verification by an independent third party**
- **Appropriate oversight requires significant auditing and data-processing capabilities**, delivered at scale statewide

An independent 3rd party vendor and the State will collaborate to:

1. **Collect** performance data from practices
2. **Audit** collected data including Gate determination
3. **Distribute** data to payers and the State
4. **Evaluate** TA Entities & best practices
5. **Manage** contracts

Overall requirements for oversight of Practice Transformation and TA Entities

Role	Description
1 **Data collection**	▪ Collect and aggregate data on practices and TA Entities, e.g., from readiness assessment, gating assessment, including administering satisfaction surveys of practices
2 **Auditing** *(TA Entities and practices)*	▪ Data quality assurance ▪ Analysis to screen and prioritize audits ▪ Audit TA Entity performance (including site visits) ▪ Audit practice performance (including site visits)
3 **Reporting**	▪ Produce and distribute reports on overall practice and TA Entity performance to practices and to payers ▪ Platform to disseminate and exchange tools and best practices
4 **Evaluation**	▪ Make performance-based recommendations to the State ▪ Evaluate best practices across the state ▪ Regular process to revise strategy, program, and execution of TA
5 **TA Entity management**	▪ Manage contracts, renewals, and payments ▪ Serve as a central point of contact across TA entities

An independent PT Oversight Body will perform some of these roles in coordination with the State

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SIM and TCPI are coordinating activities to mitigate provider confusion and maximize the potential for success of APC

Issue	Description
Communications	▪ SIM and TCPI will coordinate to ensure that communications from each program reference the total landscape of funding and assistance available
Pre-assessments	▪ TCPI and SIM will collaborate on a pre-assessment, based on the PCMH-A, that can will serve the needs of both programs and prevent duplication of effort
Oversight	▪ TCPI and SIM are exploring to what extent oversight can be shared between initiatives
Curriculum	▪ TCPI and SIM are aligning on the potential to share some curricula and teaching materials across TA Entities
Eligibility	▪ Practices will not be able to receive service from both SIM/TCPI ▪ Eligibility requirements of practices and TA Entities are being coordinated between SIM and TCPI to minimize confusion and maximize access for providers

Contents

Performance measurement and reporting: goals

Purpose: Revisit timelines and latest thinking on V1.0 scorecard

For information:

- Proposal for use of scorecard
- Need for an interim solution (V1.0) and timing
- Interim solution as a test-bed for an APD-enabled scorecard

For workgroup input:

- Degree of standardization for use of core measures in payment
- Latest view on measures and candidates for inclusion in V1.0
- Current thinking on potential approach to operationalizing V1.0 and next steps

20 core measures are proposed for inclusion in the APC scorecard

✓ Claims-only is possible

Categories		Measures	Claims	EHR	Survey
Prevention	1	Colorectal Cancer Screening	✓	✓	
	2	Chlamydia Screening	✓	✓	
	3	Influenza Immunization - all ages	✓	✓	✓
	4	Childhood Immunization (status)	✓	✓	
	5	Fluoride Varnish Application	✓		
Chronic disease	6	Tobacco Use Screening and Intervention	✓	✓	
	7	Controlling High Blood Pressure	✓	✓	
	8	Diabetes A1C Poor Control	✓	✓	
	9	Medication Management for People with Asthma	✓	✓	
	10	Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	✓	✓	
BH/Sub-stance 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	Hospitalization	✓		
	18	Readmission	✓		
	19	Emergency Dept. Utilization	✓		
Cost	20	Total Cost Per Member Per Month	✓		

For the scorecard to help drive practice performance, it must be tied to payment across multiple payers

FOR DISCUSSION

Value-based programs	Draft rule for payment weighting	Questions
Medicaid	▪ **≥80%** on Core APC quality measures (other measures limited to those associated with bundles, and CMS core measures)	▪ What Medicaid MCO measures will need to be added? ▪ How does this change for primary care practices in PPSs?
Commercial	▪ **≥80%** on Core APC quality measures	▪ What additional allowances must be made for ACOs?
Medicare advantage (MA Stars)	▪ **≥60%** on Core APC quality measures (MA Stars only other measures)	▪ What is the right limit on quality measures to recognize the need for MA stars measures?

- **Targets and benchmarks will not be standardized statewide in this iteration**
- **Continued progress and standardization will depend on ongoing collaboration with payers and providers**

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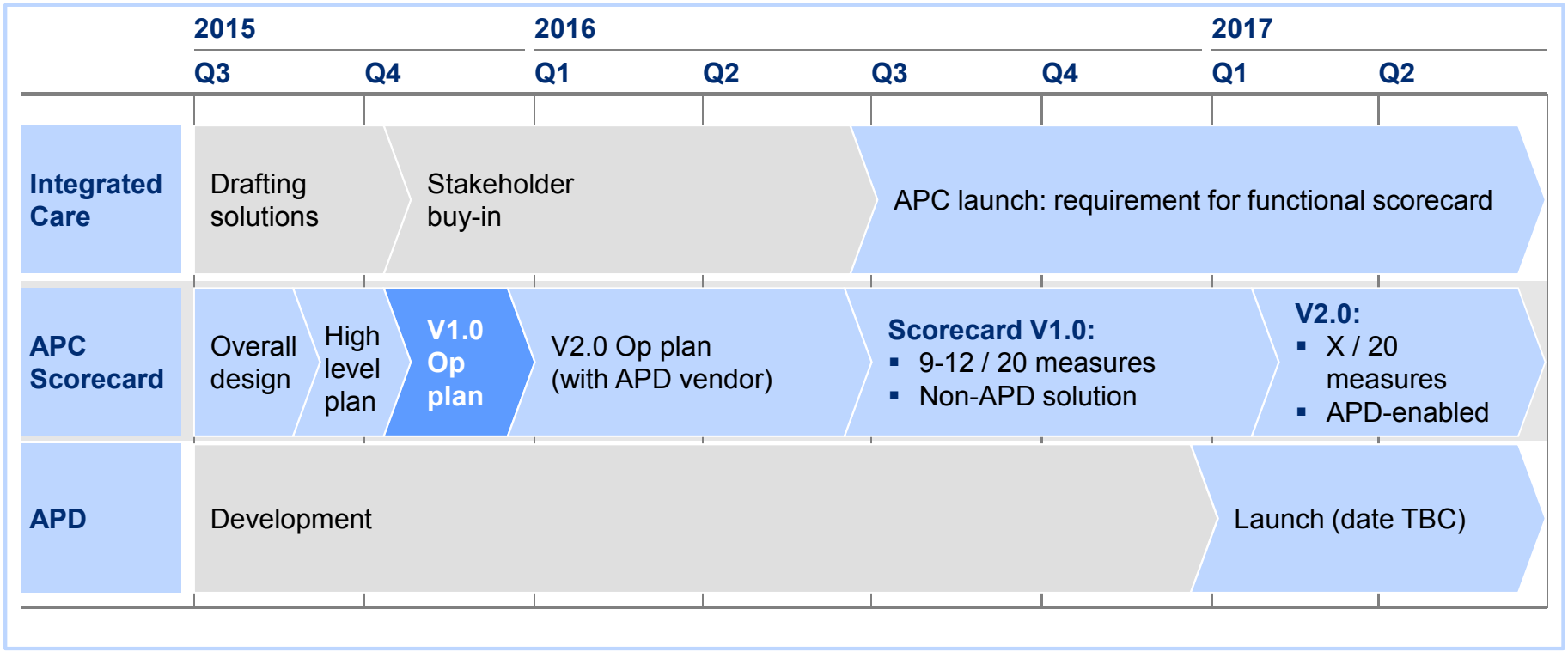
Recap: An interim scorecard approach is needed due to misaligned APC and APD timelines

Current focus



Key questions:

- *When can the state build a centralized, APD supported scorecard?*
- *When can we go from claims only measures to all measures?*

***Not fast enough to support the APC launch** – We need an interim non-APD based solution with claims only measures.*

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Of the 20 core measures proposed for the APC scorecard, 9-12 of the measures are targeted for V1.0

✓ Claims-only is possible
Candidate V1.0 measures

Categories	Measures	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	✓	✓	
	2 Chlamydia Screening	✓	✓	
	3 Influenza Immunization - all ages	✓	✓	✓
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	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
	17 Hospitalization	✓		
	18 Readmission	✓		
	19 Emergency Dept. Utilization	✓		
Cost	20 Total Cost Per Member Per Month	✓		

Creating a V1.0 scorecard allows us to bridge the timing gap, but also to create a test bed for an eventual APD-enabled solution

Goals for V1.0 phase	Includes (not exhaustive)
Enable practices to access performance reports once they've enrolled	▪ Create a baseline profile for each practice's performance ▪ Use for practice assessment, gates and milestone determination ▪ Familiarize and initiate practices with the use of the common measure set to guide their QI plans and link this to Value-Based Payments
Create a test-bed for an APD-enabled scorecard (V2.0)	▪ Troubleshoot quality assurance and data problems ▪ Begin to explore clinical e-measures and how these can be submitted and incorporated via SHIN-NY ▪ . . .

Potential approach to operationalizing the interim scorecard (V1.0)

PRELIMINARY – UNDER DISCUSSION

Payers

- Receive claims from providers
- Calculate V1.0 measures (numerators and denominators) by provider / site according to agreed standards

State

- Receives provider/site - level metrics (numerators and denominators) from all payers
- Aggregates metrics across payers to create Common Scorecard for each practice
- Designs and maintains provider portal (potentially via contractors)

Providers

- Access single, integrated scorecard across all payers
- With double-clicks by payer
- With attribution lists

Next steps

- Agree high-level design and plan to operationalize V1.0
- Identify high-level tech. solution / build option
- Work with payers and tech. provider on concrete path to operationalize V1.0
  - Identify concrete options for payer data submission (by end Jan 2016)
  - Begin payer file creation (Feb onwards)
  - Begin payer file submission as part of V1.0 testing / pilot (May onwards)
  - Launch V1.0 scorecard (July 2016)

Contents

Updates on stakeholder engagement: goals

Purpose: Provide updates on regulatory levers and stakeholder engagement

For information:

- Update on State's perspective on and approach to support APC
- Bring feedback from listening sessions to the working group
- Describe timeline for in-depth provider feedback

For workgroup input:

- How will workgroup members participate in communications and outreach in 2016?
- What other elements of outreach need clarification?

Updates on State regulatory levers

- **DFS does not currently intend to compel participation in APC in 2016**
- **We are focused on collaboratively refining the APC model to ensure it represents a good business decision for all participants**, independent of regulatory changes
- **DFS will consider positive incentives to catalyze participation, including revision of the MLR formula for State rate review** to count value-related payments in the numerator for those payers participating in the APC program
  - Input is welcome on other ways to minimize barriers to participation in APC
  - Additional specifics in this vein may not be released until after the December information request from payers
- **DFS may use its ability to collect information through rate review and other tools** to understand the level of APC participation and increase transparency where appropriate

Themes from recent conversations with payers

Theme	Description	Implications
Support for the multi-payer initiative	▪ Aligned incentives will enable true change in practices, especially those with a mix of sub-scale payer representation	▪ As a group, we need to agree on the minimum level of standardization that aligns incentives for practices
Desire for flexibility	▪ Each plan has its own programs with dedicated measures and payments and is wary of change ▪ Plans have a general desire to preserve flexibility to innovate ▪ Government programs (e.g., MA Stars) likely necessitate additional measures	▪ Without some changes to allow for standardization, APC will not change the current environment for primary care ▪ There may be targeted exceptions to Core Measure payment principles ▪ Together, we must align on what measurement and payment parameters are essential
Concern about funding financial trans-formation / care coordination	▪ Plans prefer to create value-based payments for practices already prepared to perform ▪ Investments in up-front transformation financial support and care coordination are interpreted as dissociated from performance	▪ Small and medium-sized practices at Gates 1 and 2 may not be able to make appropriate investments to transform without up-front support ▪ Transformation and care coordination payments will be clearly linked to performance through milestones
Imperative to understand the business case	▪ Payers have identified the need to understand expected investments and returns	▪ The state will disseminate principles of expected payments and returns in a generalized business case- each payer will perform its own actuarial analysis ▪ Additional understanding of the practice landscape will come as TA entities begin to interact with practices

Multiple avenues for continued feedback

- One-on-one payer meetings
- Group payer meetings
- Purchaser advisory council
- December 2015 information request

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Provider outreach and education will continue after the APC model is closer to final and payers have expressed interest

Proposed APC approach for providers

Component	Description	Proposed starting dates
Outreach and education	**Information to providers on:** ▪ APC programs including business cases ▪ TCPI and SIM-funded practice transformation details and comparison ▪ Entities available for each program	Q1-2, 2016
Indication of interest and self-assessment	**Standardized form for indication of interest, including a self-assessment** that can map to APC milestones and TCPI phases ▪ Algorithm may suggest appropriate TA Entity / program choices	Q2, 2016
Gate assessment	**Third-party assessment of Gate achievement** that can be used to: ▪ Trigger applicable APC payments from all participating payers ▪ Determine appropriate TA	Q3-4, 2016
Contract	**Signing of APC contracts/ ammendments** between payers and providers ▪ May occur concurrently with Gate assessment	Q3-4, 2016

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Appendix

For reference: APC Capabilities

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the highest-risk patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Crosswalks with allied programs should be tailored to purposes relevant to APC

Detail to follow

Purpose of crosswalks

- Better understand right level of entry for allied programs
- Allow providers that are involved in other programs to understand how their progress lines up with APC
- Ensure that milestones are sufficiently stringent in comparison to other programs

Relevant crosswalks[1]

- **A** NCQA
- **B** TCPI
- **C** MACRA
- **D** DSRIP

1 Greater New York Hospital Association has an online crosswalk of several of these programs: http://gnyha.org/whatwedo/finance-insurance-gme/nys-finance-issues/medicaid-waiver-dsrip/dsrip-crosswalk

APC Structural Milestones largely match up with NCQA 2014, with a few elements specific to APC

● NCQA 2014 "Must-pass" ○ Not mentioned in NCQA 2014
● NCQA 2014 other

	Commitment Gate 1	Readiness for care coordination Gate 2 Prior milestones, plus …	Demonstrated APC Capabilities Gate 3 Prior milestones, plus …
Participation	○ Early change plan based on self-assessment tool ○ Designated change agent / champion ○ Participation in TA Entity APC orientation ○ Commitment to achieve gate 2 milestones in 1 year	○ Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	● Process for Advanced Directive discussions with all patients	○ Plan for patient engagement and integration into workflows within one year	○ Engagement: survey, focus group, patient advisory council, or equivalent, plus QI plan based on results (yearly)
Population health			● Annual identification and reach-out to patients due for preventative or chronic care mgmt. ● Process to refer to self-management programs ○ Participate in bimonthly Prevention Agenda calls
Care Management/ Coord.		● Tracking system to identify highest risk patients for CM/ CC ● Ramp-up plan to deliver CM / CC to highest-risk patients within one year ● Behavioral health: evidence-based process for screening, treatment where appropriate, and referral	● Care plans developed in concert with patient preferences and goals ● CM delivered to highest-risk patients ● Referral tracking system ● Care compacts or collaborative agreements with medical specialists and institutions ● Post-discharge follow-up process ○ IMPACT model for depression management
Access to care	● 24/7 access to a provider (synchronous and asynchronous communication with explicit response time goals)	● Same-day appointments ● Culturally and linguistically appropriate services	● At least 1 session weekly during non-traditional hours
HIT	○ Plan for achieving Gate 2 milestones within one year ● E-prescribing	● Tools for quality measurement encompassing all core measures ● Tools for community care coordination including care planning, secure messaging ● Attestation to connect to HIE in 1 year	○ 24/7 remote EHR access ○ Secure electronic provider-patient messaging ● Meet current Meaningful Use standards ● Connected to local HIE qualified entity and using data for patient care
Payment model	○ Commitment to OBP payers representing 60% of panel within 1 year	○ OBP contracts with payers representing 60% of panel	○ OBP contracts with payers representing 60% of panel ○ Minimum upside risk-sharing

Must-pass elements make up only 27.5 points (out of 85 points needed for level 3)

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APC performance milestones are similar, with greater expectations for yearly performance

- NCQA 2014 "Must-pass"
- NCQA 2014 other
- NCQA "Must-pass", with slightly different measures
- Not mentioned in NCQA 2014

	Gate 1 Commitment	Gate 2 Readiness for care coordination	Gate 3 Demonstrated APC capabilities	Yearly performance against core measures within APC
Objective	Ensure practices can measure, report and engage with core measures in preparation for performance improvement			Ensure practices are using APC capabilities to drive improved performance
Proposed milestones	**Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	**Report and use data** on all core measures, including data necessary to assess health disparities **QI plan:** On at least one claims-based measure	**QI plan:** on 3 prioritized core measures, including utilization and addressing health access and outcome disparities **Positive trajectory** on utilization/cost core measures while meeting quality expectations	**Closure of gap** to agreed-upon benchmark on 3 core measures (including at least one utilization measure), while meeting yearly core measure quality expectations **Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

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Several components of NCQA are not included in APC

- **2A**: Components for continuity (orienting patients to practice, ensuring access to preferred provider, documenting care plan for transition from pediatric to adult medicine)
- **3A**: Patient information and 3B: Clinical data– practice uses electronic system to record patient information as structured (searchable) data on basic factors
- **3E**: Implement Evidence-Based Decision support
- **4E**: Support Self-Care and Shared Decision-Making
- **5A:** Test tracking and follow-up

Source: NCQA PCMH 2014 Intro training slides

Practical details

What does this mean in practice?

- Integrated Primary Care contractors would contract the Preventive services, Sick Care services and (if they so choose) the episodes included in IPC:
  - Upper Respiratory Infection
  - Allergic Rhinitis / Chronic Sinusitis
  - Tonsillectomy (downstream costs)
- IPC contractors would have the option to include (some episodes within) the Chronic Bundle
- For practical purposes, a MCO could translate this combination into a PMPM with upside only shared savings (Level 1), or up-and downside savings/losses (Level 2).
  - What portion of the episodes the MCO pays to the IPC can be negotiated by the IPC contractor and the MCO
  - Shared savings could be significant, because of relative high cost of downstream care within sick care, the chronic bundle and other downstream costs

What does this mean in practice?

- IPC providers can be a partner in Level 2 contracts
- IPC providers can lead Level 2 contracts by
  - e.g. negotiating adequate risk-mitigation conditions
  - by including partners that have the resources to accept risk
  - by realizing reserves through starting with level 1 contracts
  - Etc
- Current VBP arrangement is limited to Medicaid-only patients (not the Dually Eligible)
  - Currently in discussion with CMS to extend VBP Arrangements to Duals and Medicare FFS
  - The State will allow PCPs enrolled in current CMMI programs that include shared savings to include Medicaid patients in these programs (the MCO will have to agree).

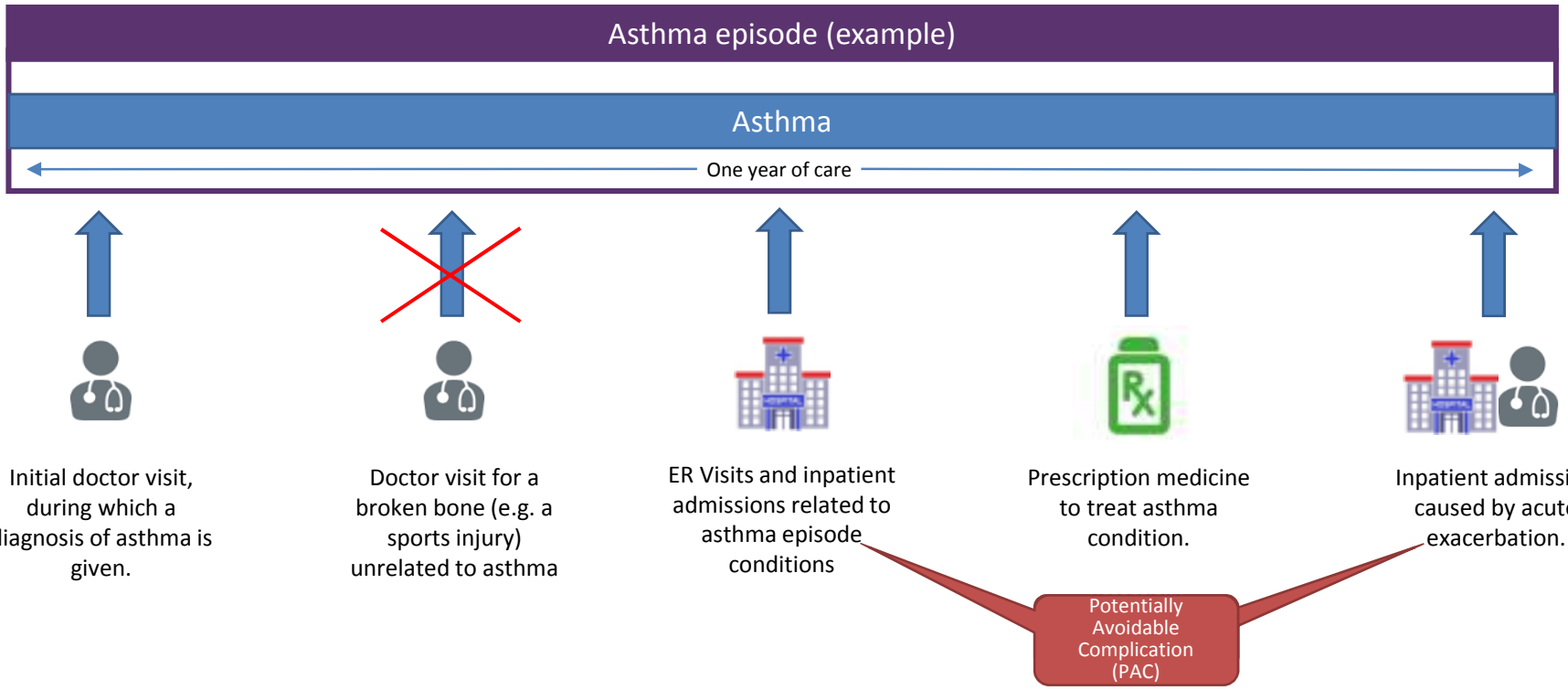
Flexibility

- There is no obligation to contract IPC separately
  - it only makes sense when there is sufficient infrastructure in place to take on this responsibility for both outcomes and costs
  - Level 2 contracts only make sense with larger numbers of patients (at least 5,000) to prevent significant losses due to random variation
- Not all chronic episodes that make up the chronic bundle need to be contracted – but that also means less opportunity for shared savings
  - The definitions of the individual episodes are standard

Flexibility

- How the MCO pays for the Preventive and Sick care components is up to the negotiations between the IPC contractor and the MCO
  - Shared savings arrangements should not cover preventive care because these volumes usually need to be increased
  - Similarly
- The MCO and IPC contractor may agree to extend the shared savings / losses arrangement to more downstream costs than those included in the ‘sick care’ costs and the Chronic Bundle
  - E.g. care coordination for cancer patients
  - Including *all* downstream costs would turn the IPC into a physician-led Total Care for the Total Population (ACO) provider

How does a bundle work?



What about the three added bundles?

- Upper Respiratory Infection
- Allergic Rhinitis / Chronic Sinusitis
- Tonsillectomy (downstream costs)

Episode Name	Episode Id	Episode Description	Annualized Volume*	Per Episode Annualized Split Costs*	Annualized Split Total Cost*	Total Split PAC Costs %	Avg Annualized Split Cv
URI	EA0303	Upper Respiratory Infection	1,036,593	$157	162,733,014	2%	0.84
RHNTS	EC0301	Allergic Rhinitis/Chronic Sinus..	302,654	$541	163,682,480	22%	1.69
TONSIL	EP0301	Tonsillectomy	9,186	$2,060	18,926,282	8%	0.59

ADHD potentially to be added to this list

What about the three added bundles?

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TONSIL	EP0301	Tonsillectomy	9,186	$2,060	18,926,282	8%	0.59

- These bundles are not intended to be contracted *separately*, because the first two conditions are part and parcel of basic primary care
- Tonsillectomy is more and more seen as (usually) a non/low-value added procedure

As part of the IPC contract, shared savings opportunities are e.g. optimizing AB utilization, wisely using diagnostics and reducing unwarranted tonsillectomies.

ADHD is being considered here because a) creating a separate bundle will create significant upward incentive to diagnose more cases; b) contrary to other bundles, there are no real 'downstream costs' or avoidable complications. They key impact of an ADHD bundle is to impact treatment modality. TBD whether that is a sufficient enough reason to consider creating a separate bundle.

FAQs

Question	*Answer*
Who can be an IPC Contractor?	An IPC Contractor can be a (group of) PCP practices, or PCP practices working together with BH providers and community-based organizations, but it can also be a hospital system employing PCPs or contracting with PCPs.
What does it mean to **contract an 'episode'** for an IPC contractor, who is not in control nor financially responsible for e.g. inpatient care?	Contracting episodes implies assuming responsibility for the total costs of the care of that episode. In Level 1 and 2, the IPC will only be paid for the care it delivers itself – downstream costs will be paid by the MCO to these downstream providers. All these costs, however, will be grouped together in the 'virtual budget' that is available for the total episode. These *total* costs will determine whether there will be savings or losses to share.
Should **the PMPM for the IPC** be determined by the costs of Preventive services, Sick care and the Chronic Bundles as determined by the HCI3 grouper?	No. There may be a need for more preventive services, for example. And the part of the care IPC handles within the chronic bundles may vary from provider to provider. The cost breakdown from the grouper of the preventive services, sick care and the chronic bundle, therefor, need not determine the size of the payments to an IPC contractor. When capitation or 'virtual budget' arrangements are already in place between an IPC contractor and a MCO, it will be wise to keep those as a starting point for further negotiations. From the perspective of the MCO, however, these IPC payments are a cost that it will want to subtract from the total amounts of funds available for the chronic bundle and all the other care it will need to contract.
What does it mean that the IPC VBP arrangements includes the Upper Respiratory Infection, Allergic Rhinitis / Chronic Sinusitis, and 'Tonsillectomy' bundles?	In the NYS VBP Roadmap, these bundles are not contracted separately. Contracting Tonsillectomy's separately would contract an intervention that is more and more considered to be considered of low value (except for rare cases). URI and Allergic Rhinitis/Sinusitis are part and parcel of IPC, and should therefore also not be contracted separately. Tracking the costs and PACs of these bundles however is useful for both the IPC contractor as for the plan contracting IPC.

Draft high-level design specifications for V1.0

PRELIMINARY DRAFT – FOR DISCUSSION / REFINEMENT

Design features	"Must have"	Desirable *(additional)*
# Measures	▪ 9-12 claims-based measures	▪ Clinical measures / e-measures
Underlying data source	▪ Numerators and denominators for claims-based measures (provided by payers) – Used to report aggregated measures (practice level as needed)	▪ Measures based on clinical data sources (e.g., pre-calculated from EHR systems, could be submitted via RHIOs/SHIN-NY –TBC)
Measure 'unit'	▪ Practice level, plan-specific (based on aggregating payer measures at provider/site level – assumes sufficient attributed pop size)	▪ Practice level, across all plans (based on aggregating payer measures at provider/site level across plans to create full practice view)
Performance comparisons	▪ Performance vs. own baseline (as feasible - baseline period = first year V1.0) ▪ Performance vs external benchmarks – National benchmarks (for HEDIS measures)	▪ Performance vs external benchmarks? – NY State benchmark for QARR measures?
Attribution information	▪ Attribution list so that practices can see who is in their panel and methodology (HIPAA compliant storage req'd)	▪ tbc
Report versions (by user)	▪ Individual practice report – Measures at practice level? – Breakdown by plan?	▪ Individual payer reports – Scorecard performance of practices with which the payer transacts ▪ State reports – Scorecard performance of practices across state, by region, type etc
User type / number of accounts	▪ Individual practices – How many user accounts per practice? ▪ Potentially other parties in connection with APC gate assessment requirements	▪ Individual payers – How many user accounts per payer? ▪ State – How many user accounts within the state?
Reporting frequency	▪ Annual (+ Quarterly?) ▪ YTD for YoY comparison?	▪ Quarterly? ▪ Rolling 12-month view?
Report channel / interactivity	▪ Static electronic report (e.g. pdf)	▪ Interactive, dynamic web portal
User support	▪ Phone or email support for trouble-shooting, queries, attribution concerns etc?	▪ tbc

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