NEW YORK STATE OF OPPORTUNITY. Department of Health

Integrated Care Workgroup

Meeting #12

Discussion document

February 8, 2016

Agenda

Timing	Topic	Lead
10:00-10:30am	Welcome / updates on APC publications	▪ Foster Gesten, John Powell
10:30-10:45am	Update on APC scorecard	▪ Foster Gesten, Anne Schettine
10:45-12:15pm	Milestones update	
	▪ Performance milestones	▪ Foster Gesten
	▪ Structural milestone details	▪ Marcus Friedrich
	▪ Behavioral health update	▪ Henry Chung
12:15-12:30pm	Working lunch	
12:30-01:15pm	APC alignment with other programs	
	▪ APC / TCPI alignment	▪ Hope Plavin, Tom Mahoney
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Our core working group has been working on multiple materials for publishing

Activity	Description	Status	Next steps
FAQ	Frequently Asked Questions on APC, including model design, reasons to participate, and approach to special cases	▪ Distributed to ICWG ▪ Published on APC website	▪ Published
Business case	Assumptions and associated financial implications of a general business case for payers and providers	▪ Discussed at last ICWG	▪ N/A
Information request	Written request of NYS payers to understand current approach to primary care payment and future approach to APC	▪ Released February 4th	▪ Responses due early March ▪ Q&A mid February
Milestones technical specs	Details behind each milestone defining what it means to “pass” and materials required in submission	▪ Draft shared ahead of today’s meeting	▪ Finalization this month
PT RFA	Request for applications for practice transformation technical assistance entities, using a majority of the $67M earmarked for practice transformation	▪ Draft complete, in final approval stages	▪ Release Q1 2016
Oversight RFP	Request for proposals for single APC oversight entity, auditing and verifying PT TA performance and milestone achievement	▪ Draft in progress	▪ Release Q1 2016

Reminder: APC timeline to ensure launch with scale

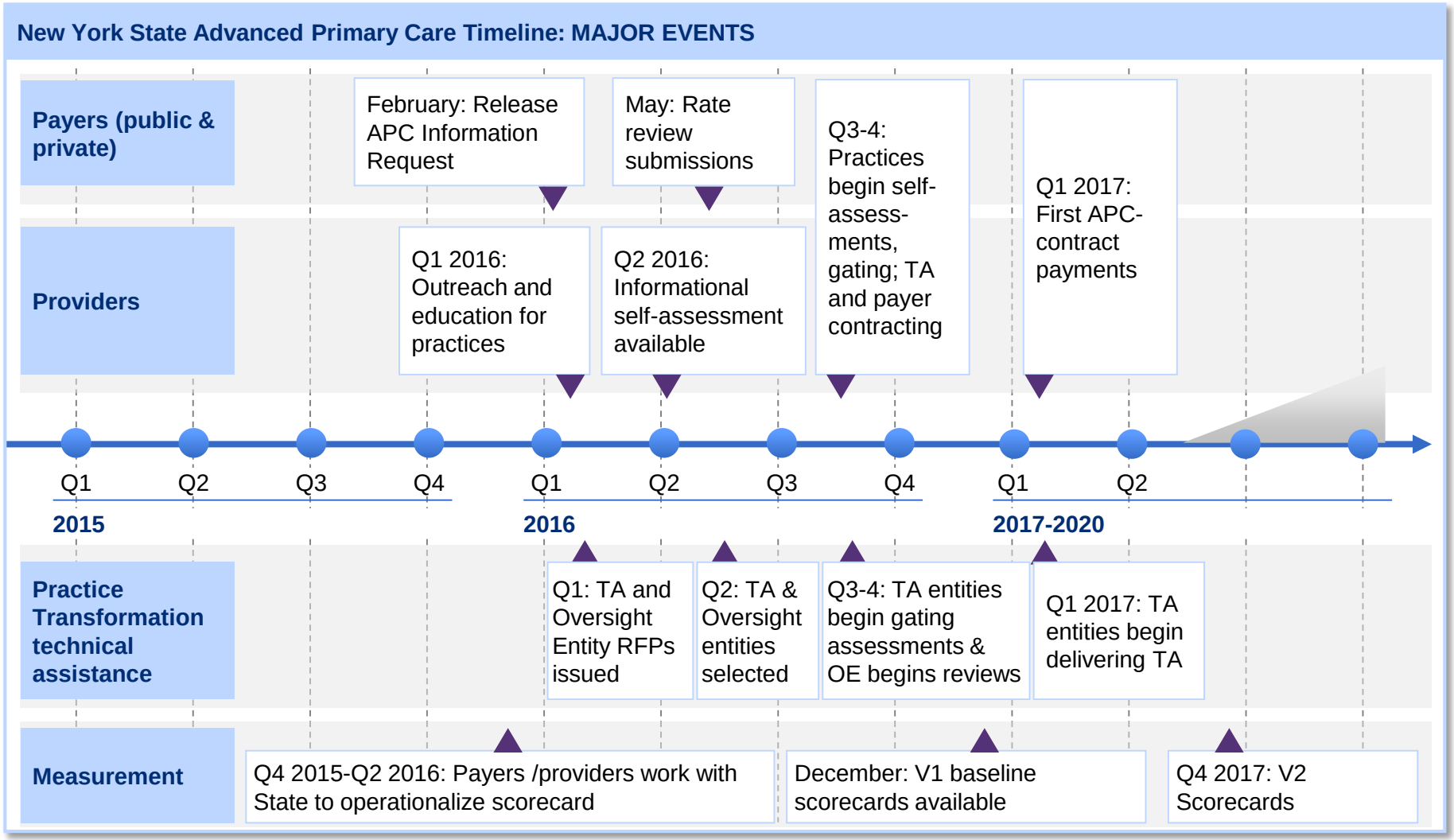
Context
Stakeholder, technical, and operational realities

- **Payer 2016 budget cycles** are set; new 2016 investments would be disruptive and difficult to obtain
- **Rate review** approves rates for new calendar year
- **Vendor timelines** are tight and critical to ensure smooth start-up at scale
- **Scorecard alignment** on strategy, specs, and operational plan ongoing

Refined timeline
Continued refinement 2016, staged launch starting Q3 2016, full launch January 2017

- **Q1-Q2 2016:** Continue **payer commitments to APC**, aligned payment models, Rate Review submissions, and scorecard alignment
- **Q3 2016: Provider** self-assessments, gating, and TA service contracts begin
- **Q3 2016: Provider-payer contract amendments**
- **Q4 2016: Baseline scorecards**
- **Q1 2017: Performance periods and TA** begin for most practices (selected practices may begin PT earlier)

Overview of 2016 major events leading to full Jan 2017 implementation

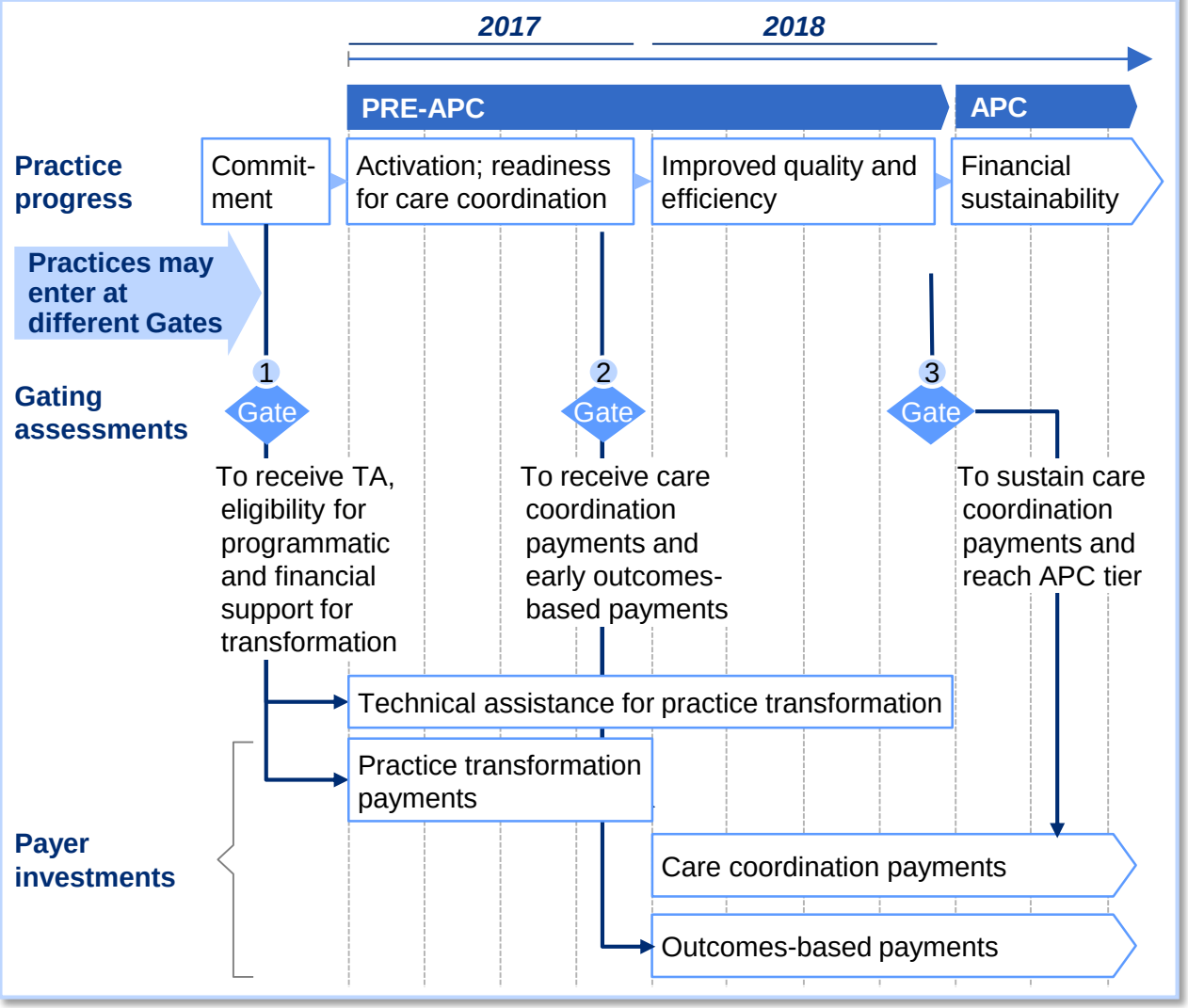


Overview of APC model

- This reviews a **common APC framework** in which individual payers develop and implement APC-qualified contracts
- Components of APC include:
  - Practice **Capabilities** within the APC model
  - **Milestones** that define a practice's capabilities over time
    - **Structural milestones** – describing practice-wide process changes
    - **Performance milestones –** describing performance on Core Measures
  - **Core Measures** that ensure consistent reporting and incentives
  - **Outcome-based payments** structured to promote and pay for quality and outcomes

A common on-site assessment determines initial starting points and certifies practices' progress through **Gates** which mark progress through pre-specified structure/process and performance Milestones, triggering payer commitments such as payments

Review: path to APC for a practice starting at Gate 1 in 2017



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The APC scorecard aspires to include 20 common measures

Categories		Measures	Measure steward	Claims	EHR	Survey
Prevention	1	Colorectal Cancer Screening	HEDIS	✓	✓	
	2	Chlamydia Screening	HEDIS	✓	✓	
	3	Influenza Immunization - all ages	AMA (all ages) or HEDIS (18+)	✓	✓	✓
	4	Childhood Immunization (status)	HEDIS	✓	✓	
	5	Fluoride Varnish Application	CMS (steward), NQF, MU	✓		
Chronic disease	6	Tobacco Use Screening and Intervention	CMS (steward), NQF, MU	✓	✓	
	7	Controlling High Blood Pressure	HEDIS	✓	✓	
	8	Diabetes A1C Poor Control	HEDIS	✓	✓	
	9	Medication Management for People with Asthma	HEDIS	✓	✓	
	10	Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	*Children*: HEDIS *Adults:* CMS	✓	✓	
BH/Substance abuse	11	Depression screening and management	CMS	✓	✓	
	12	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	✓		
Patient reported	13	Record Advance Directives for 65 and older	HEDIS	✓	✓	✓
	14	CAHPS Access to Care, Getting Care Quickly	HEDIS			✓
Appropriate use	15	Use of Imaging Studies for Low Back Pain	HEDIS	✓		
	16	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	HEDIS	✓		
	17	Hospitalization	HEDIS	✓		
	18	Readmission	HEDIS	✓		
	19	Emergency Dept. Utilization	HEDIS	✓		
Cost	20	Total Cost Per Member Per Month		✓		

In our last meeting, we agreed that a version 1.0 of the APC Scorecard is needed as a bridge to the APD launch

Ultimate goal for APC Scorecard:

- A statewide report aggregating all primary care data relevant to APC Core Measures
- The first tool to enable practices to view their performance across a consistent set of measures for their entire patient panel (rather than on a per payer basis)
- The basis for practices to pass APC gates and access outcome-based payments

Proposed interim solution (Scorecard version 1.0):

- Scorecard reporting statewide practice performance on 13 measures (including 2 interim process measures) that can be generated from claims-only data
- Payers submit numerators and denominators of measures to the State
- Data accessible to payers and providers

Version 1.0 will focus on 11 claims-only measures and 2 interim process measures

Proposed for version 1.0

Categories	Ultimate measures	Proposed interim measures
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	**Member-level composite (HbA1c test + Eye Exam + Nephropathy) (HEDIS)**
	9 Medication Management for People with Asthma	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	
BH/Substance abuse	11 Depression screening and management	**Antidepressant medication management (HEDIS)**
	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	

Payer Capabilities and Preparation Needs

A survey and follow up interviews with 6-8 payers will be conducted to gather:

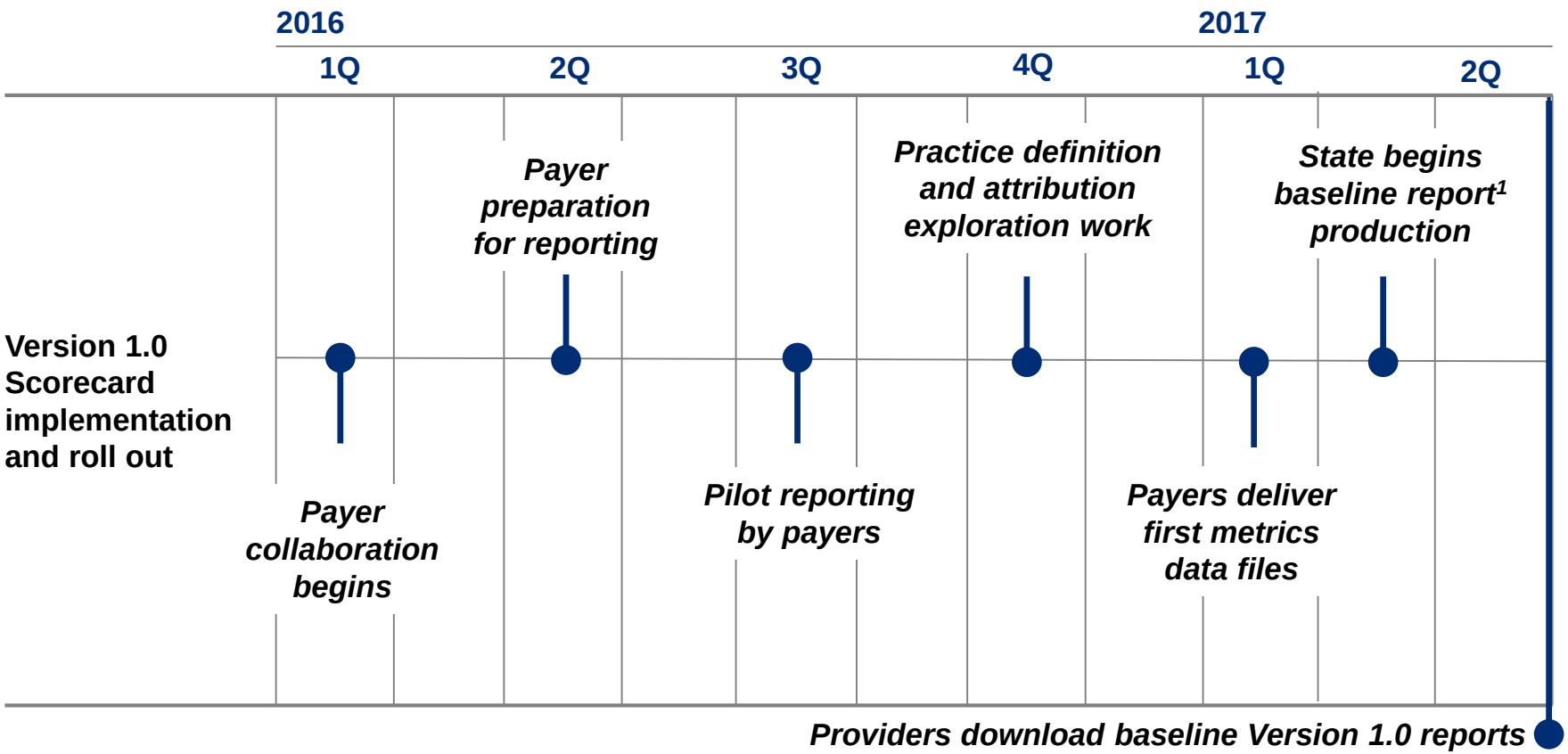
- **Ability with resources needed to collect and report HEDIS data quarterly with 12 month rolling year**
- **Systems used for quality reports with providers**
- **Ability to add new or non-HEDIS measures**

We are collecting payer feedback on version 1.0 specifications

1	**Measures**	11 claims-only and 2 interim process measures are proposed for version 1.0
2	**Reporting frequency**	Reports produced quarterly, with one comprehensive annual report
3	**Reporting window**	12 month rolling window[1]; run out period of 3 months
4	**Unit of reporting**	Numerators and denominators should be reported at a de-identified member level with practice information associated to the member *(NB: the State will not handle PHI as part of this process)*
5	**Practice definition**	Payers will send information regarding providers and practices associated with the member quality measure result; state will aggregate into practice-level statistics
6	**Data source**	Version 1.0 will rely on administrative data only; later versions will incorporate clinical information as well
7	**Patient to provider attribution**	Attribution methodology will be left to payer discretion; information about attribution methodologies will be gathered and summarized in the pilot phase to inform later version of the scorecard; a sample of practices will be surveyed to verify accurate attribution to practices
8	**Population and risk adjustment**	Measures should be calculated across all members for a given payer and risk adjusted according to existing measure guidelines.
9	**Data submission format**	Data will be submitted in a flat file data table through a data submission tool to IPRO
10	**Provider eligibility**	At minimum, payers will submit data for APC providers and for commercial, Medicaid, and Medicare Advantage lines of business; ideally payers will submit data for all practices
11	**Timeline**	Planned release date for version 1.0 of the scorecard is first quarter 2017

1 A period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar month

Version 1.0 launch is planned for January 2017



1 Baseline reports are based on recent 12-month performance

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Discussion questions

To discuss:

1. Can these measures be generated with sufficient accuracy from claims data?
2. What additional vetting of these measures for this process is needed?
3. How will version 1.0 be operationalized?
   a) Which specifications pose the biggest challenges, and how should we address them?
   b) What will it take from payers, providers, and the State to stand up version 1.0 in 2016?

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APC performance milestones

DRAFT

	Gate 1 Commitment	Gate 2 Readiness for care coordination	Gate 3 Demonstrated APC capabilities	Yearly performance against core measures within APC (determined in each payer/provider contract)
Process	▪ **Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	▪ **Report and use data** on all core measures[1], including data necessary to assess health disparities ▪ **QI plan:** Plan to achieve performance gate requirements by Gate 3	▪ **QI plan:** on 3 prioritized core measures, including utilization and addressing health access and outcome disparities	
Performance on Quality			▪ **>50th percentile (Statewide on base year 2015) on 4/7 process quality measures[2]** ***OR if below 50th percentile:*** ▪ **50% annual closure of gap to 50th percentile based on prior 2-year rolling baseline, on 4/7 quality process quality measures**	▪ **Meet or exceed contracted quality benchmarks**
Performance on Utilization			▪ **>50th percentile on 2/3 utilization measures (Statewide on base year 2015 hospitalizations, readmissions, and ED use)** ***OR if below* 50th *percentile:*** ▪ **10% annual closure of gap to 50th percentile based on own prior 2-year rolling baseline in 2/3 of the following measures:** – **Hospitalization** – **Readmission** – **ED utilization**	▪ **Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

1 Of measures being reported at that time (i.e., in 2016 the V1 scorecard will report on a subset of the 20 APC Core Measures)
2 Measures 2, 4, 5, 9, 12, 15, 16 from following page- subject to change on an annual basis and upon roll-out of V2 scorecard

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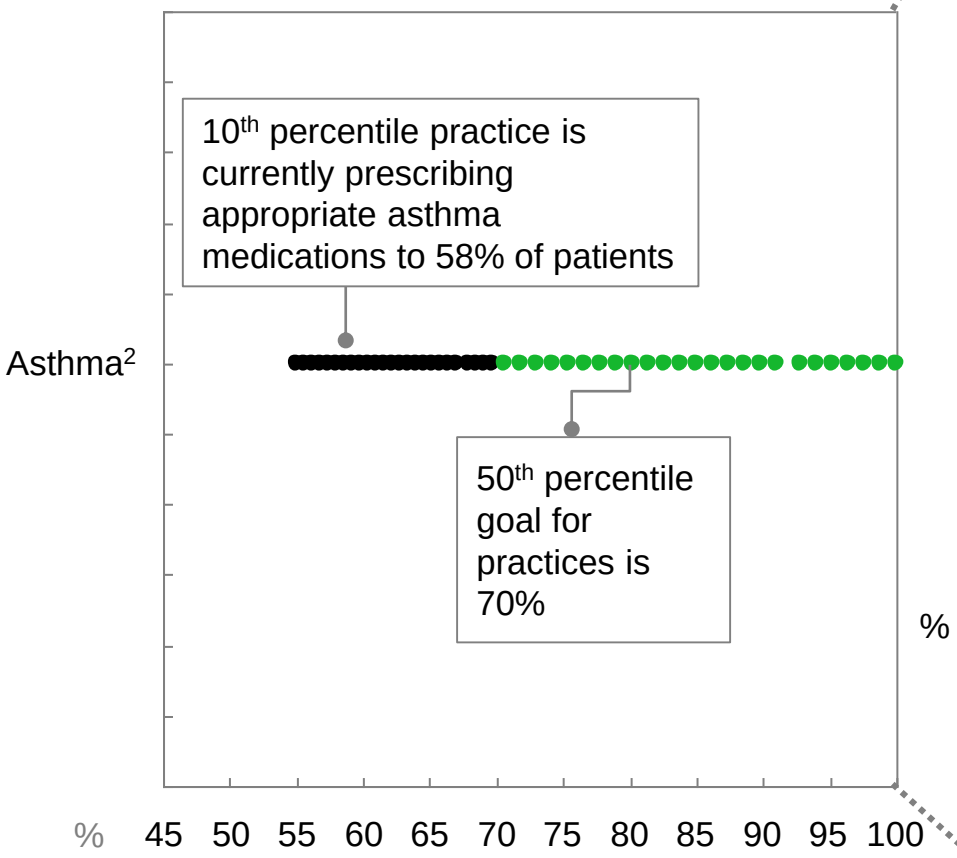
Illustrative example of performance improvement expectations in practice

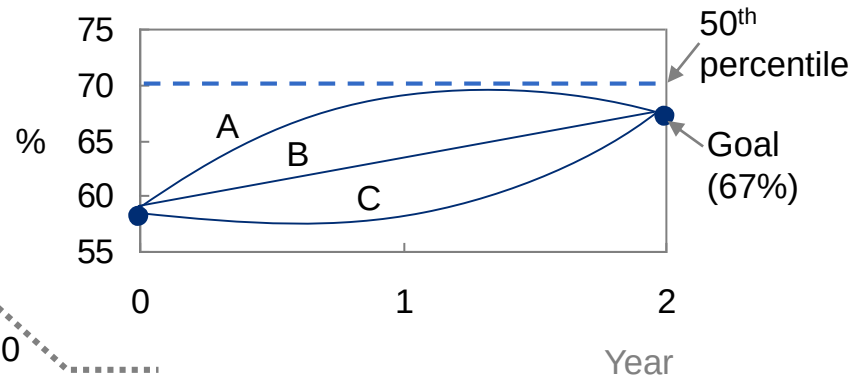
● Historical results below 50th percentile

● Historical results at or above 50th percentile

Quality metric baseline practice data from a statewide primary care program[1]



- A practice that enters a Gate 1 has to close its "gap to goal" twice over two years
- If the 50th percentile is 70% appropriate prescribing and the practice is currently at 58%, its goal in 2 years is 67%
  - Year 1: must get to 64%: 58%+(0.5*(70%-58%))
  - Year 2: must get to 67%: 64% + (0.5*(70%-64%))
- Practice is only assessed at year 2, so the year 1 measurement is not factored into Gate achievement (paths A, B, and C below all count)



1 Based on publicly available Arkansas PCMH baseline data, 2012-2013
2 Percentage of patients prescribed appropriate asthma medications

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APC structural milestones are the product of more than a year of work building on the experience of other primary care programs

APC structural milestones that follow on the next page (and the detail included in today's pre-read):

- Result from more than a year of thinking across a wide range of stakeholders
- Represent the collective guidance of a range of experts including, but not limited to:
  - Providers
  - IT experts
  - Technical assistance providers
- Build on the experience of what works in other primary care programs and discard what does not, including the examples of:
  - NCQA
  - CPCi
- Directly link to the Advanced Primary Care capabilities we have collectively defined over the past year
- Shift requirements from box-checking to a focus on what really matters

APC structural milestones

Proposed addition ~~Proposed removal~~
Proposed change

DRAFT

	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*	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*
Participation	i. **APC participation agreement** ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	**Prior milestones, plus …** i. Participation in TA Entity activities and learning (if electing support)	**Prior milestones, plus …**
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. **Advanced Directive discussions with all patients >50** ii. Plan for patient engagement and integration into workflows within one year	i. **Advanced Directives shared across medical neighborhood, where feasible** ii. **Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)**
Population health			i. Participate in Prevention Agenda ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to self-management programs
Care Manage-ment/ Coord.	i. **Commitment to developing care plans in concert with patient preferences and goals** ii. **Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year** ~~iii. Patients empaneled to practice and care teams~~	i. **Identify and empanel highest-risk patients for CM/CC** ii. **Process in place for Care Plan development** iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	i. **Integrate high-risk patient data from other sources (including payers)** ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system **in place** v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. **Behavioral health: Coordinated care management for behavioral health**
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ~~ii. Tools for community care coordination including care planning, secure messaging~~ iii. **Certified technology for information exchange available in practice for** iv. Attestation to connect to HIE in 1 year	i. 24/7 remote access to **Health IT** ii. Secure electronic provider-patient messaging iii. **Enhanced Quality Improvement including CDS** iv. **Certified Health IT for quality improvement, information exchange** v. Connection to local HIE QE vi. **Clinical Decision Support**
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel

Technical specifications can be found in pre-read

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework

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Technical specifications for structural milestones – focus areas for discussion

Focus area	Discussion topic
Reporting burden	▪ Can we better balance the practice and TA Entity time and investment burden generated by the level of reporting required with the necessity to measure progress to justify payer investments?
Level of prescriptive-ness	▪ How can we adjust the level of prescriptiveness of the milestones to ensure that they are meaningful while preserving room for practice innovation and minimizing administrative burden?
Alignment with other programs	▪ Acknowledging our desire to tailor APC to NY and the proprietary nature of NCQA, are there additional opportunities to better align the milestones with existing programs while preserving the integrity of the program we have designed together?

Detailed behavioral health structural milestones

	Commitment Gate 1	Readiness for care coordination Gate 2	Demonstrated APC Capabilities Gate 3
	What a practice achieves on its own, before any TA or multi-payer financial support	***What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet***	***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***
Behavioral health	i. Self-assessment for BH integration and plan for achieving Gate 2 BH milestones within 1 year	**Prior milestones, plus …** i. Evidence-based process for screening, treatment where appropriate, and referral for uncomplicated, non-psychotic depression	**Prior milestones, plus …** i. Coordinated care management for behavioral health
Milestone definitions	i. Self-assess level of BH integration and concrete plan for reaching Gate 2 within 1 year	i. Evidence-based process for screening, treatment where appropriate, and referral for uncomplicated, non-psychotic depression supported by: ▪ Use of PHQ2/PHQ 9 for screening of depression ▪ Demonstration of policies, procedures and capacity for evidence based follow up ▪ Completion of approved CME course for primary care treatment of depression ▪ Signed MOU with BH provider including required elements for communication and enhanced engagement	i. Coordinated care management for behavioral health supported by: ▪ Demonstration of connection to on site or shared care management resources, including health home care managers ▪ Sharing and review of care plans electronically ▪ Linkage with social service agencies for concrete services ▪ Demonstration of follow-up after screening and referral tracking

- Proposed V1 score-card BH measure is anti-depressant persistence at 3 months (HEDIS)

Questions for you

For discussion

1. Do the performance milestone improvement expectations strike the appropriate balance of demanding positive provider trajectory while ensuring the majority of practices can transform through APC?
2. Do the structural milestones and their technical details provide the right level of detail and adequately capture what we are asking practices to do in the model we have designed together?
3. Would you like to be part of a focused follow-up discussion in two weeks to offer additional feedback on the technical details?
4. Do the behavioral health milestones reflect the natural progression of our discussion to date?

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TCPI overview and comparison with SIM/APC

TCPI Overview

CMMI-funded National Initiative to support practice transformation

3 programs in NYS - > $50 million

- NYSPTN – NYeC, FLHSA, DOH
- GNYCPTN – NYU (Brooklyn)
- Council of Behavioral Health (BH focus)

Status:

- Contracting with TA providers
- Planning to go-live in spring, 2016

TCPI vs. SIM/APC

Similarities

- Primary care practice transformation
- Goal: Prepare practices for VBP
- Regional approach to practice transformation
- Using many of the same TA's as DSRIP,SIM

Differences

- TCPI Focus – primary care and specialty
- Slightly different curriculum
- Linkage to payment reform
  - SIM/APC proposes payers/payment change
  - TCPI does not

The Imperative: Align, coordinate TCPI and SIM/APC (and DSRIP) to increase their collective impact

Current level of alignment between TCPI and APC

Key Areas of Alignment	Coordination in Progress	Aligned with details to be finalized	Partial alignment with exceptions (TBD)
Common Tools for Provider Assessment, Self-Assessment	DOH, NYS PTN, NYU PTN staff	Final approval and technical formatting to be available for portals	
Common, Competencies and Coordinated Curricula	NYSDOH, NYSPTN, NYU PTN	Consensus pending on alignment of curriculum and technical specifications (Leadership meeting scheduled mid-February)	
APC Milestones, TCPI and DSRIP Phases and Milestones	NYS DOH, PTNs, OHIP		Identify specific APC Milestones required for Gating that are not required for TCPI graduates
"Mapping" TCPI completion to APC Gating Criteria	NYSDOH, NYSPTN, NYU PTN		
Tracking TA and Provider Engagement, Enrollment, non-duplication	NYS Center for Health and Workforce Studies (CHWS), NYeC, NYU PTN, NYS DOH	Discussion and strategy meetings in progress	
Marketing Communication Strategies	DOH, NYSPTN, NYU PTN	(Leadership meeting scheduled mid-February)	

Development of a Practice Transformation Reporting System (1/2)

- Effective practice transformation is critical to the success of primary care transitions to Advanced Primary Care (APC) or to achieving higher levels of PCMH
- Technical assistance in support of practice transformation is currently provided by TCPI networks and Performing Provider Systems under DSRIP
- In the future, resources will be made available under SIM to support additional technical assistance on practice transformation
- It is critical to track the provision of technical assistance in order to:
  - Document current targets of practice transformation assistance
  - Identify unmet need
- The system can also be used to prevent redundancy and duplication of services

Development of a Practice Transformation Reporting System (2/2)

The New York Center for Health Workforce Studies will develop a database that includes:

- All primary care physicians and physician practices that provide primary care services
- An internet-based interface that will allow users (i.e., those providing technical assistance)
  - To report on their provision of technical assistance
  - To identify additional physicians/practices that could benefit from this outreach
- Track progress and status of physicians/practices achieving APC or PCMH status

The Center will build the database using a variety of data sources, including:

- New York State Education Department licensure data
- Provider Network Data System (PNDS)
- Other state and federal data sources to verify specialty, address, and other practice or provider information

The database will include both provider and practice information, with linkages between the two

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As we approach the launch of APC in 2016, we are shifting to implementation of the model we have designed together over the past year

Moving from design to implementation planning requires a shift in workgroup focus:

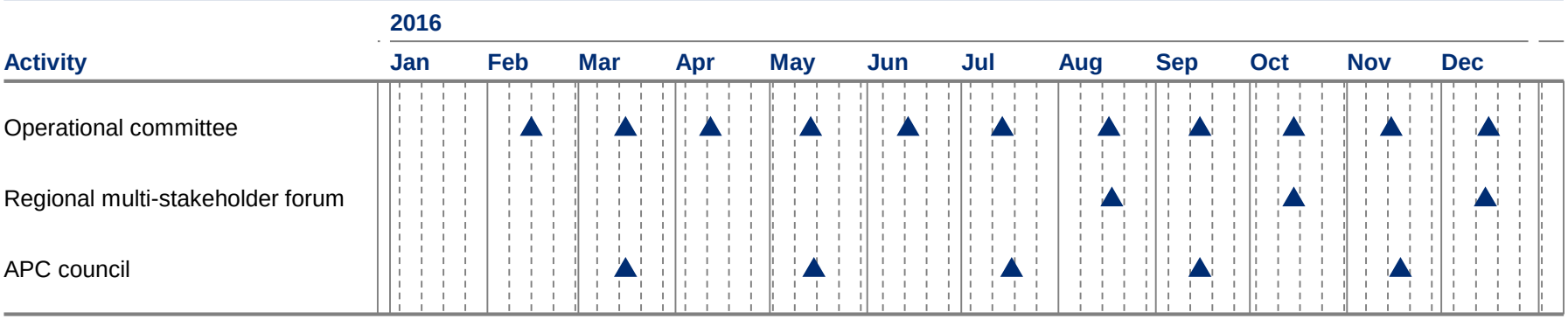
From	To
How do we design the best APC model?	How can we implement the model to drive the intended impact?
Informal conversations with and between APC stakeholders	Structured, formal interactions with APC participants (e.g. payer information request due in March)
Understanding allied programs across the State	Aligning programmatic and operational aspects of complementary programs under the APC framework to maximize value

To facilitate this shift, meeting entities will also change focus

Proposed entities	Description / participants	Role	Frequency
Operational committee	▪ Payers and providers that have committed to APC ▪ Statewide, with State convening	▪ Provide feedback on and proposals to improve implementation of APC ▪ Cross stakeholder dialogue to identify and resolve any critical issues	▪ Monthly to start (payer-only) ▪ Providers to join as implementation progresses ▪ Stakeholder-specific breakouts as needed
Regional multi-stakeholder forum	▪ Providers, TA entities, and payers (optional) meeting by region / multi-region group ▪ Facilitated by PHIPs or similar regional convener	▪ Discuss operational concerns by region ▪ Create regional reports to be reviewed by the State and discussed at APC council	▪ Every other month starting Q3 2016
APC council *(re-definition of ICWG)*	▪ Representatives of all stakeholders, with representation of regions when active ▪ Current ICWG members who choose to continue participating ▪ Statewide, with State convening	▪ Discuss ongoing progress by region and statewide ▪ Forum for coordination and adjustment with allied initiatives ▪ Advise State on changes to model	▪ Every other month (potential to progress to quarterly)

Success will be defined as the finalization and implementation of the APC model:
- **In accordance with the timelines previously set**
- **Positive trajectory toward meeting SHIP goal of 80% of New Yorkers covered by APC model**

Proposed 2016 timeline



Questions for you

For discussion

1. What critical issues do you anticipate that would not have a place in any of the proposed meeting entities?
2. Do you want to continue your participation as the APC council is formed?

Agenda

Timing	Topic	Lead
10:00-10:30am	Welcome / updates on APC publications	▪ Foster Gesten, John Powell
10:30-10:45am	Update on APC scorecard	▪ Foster Gesten, Anne Schettine
10:45-12:15pm	Milestones update	
	▪ Performance milestones	▪ Foster Gesten
	▪ Structural milestone details	▪ Marcus Friedrich
	▪ Behavioral health update	▪ Henry Chung
12:15-12:30pm	Working lunch	
12:30-01:15pm	APC alignment with other programs	
	▪ APC / TCPI alignment	▪ Hope Plavin, Tom Mahoney
	▪ TA database and workforce efforts on care managers	▪ Jean Moore
01:15-01:45pm	Governance update	▪ Foster Gesten
01:45-02:00pm	Closing	▪ Foster Gesten

Appendix

Approach to ensuring statistical validity

Considerations

1 Guidance on statistically significant sample size

- Minimum required sample size is lower for metrics expressed as percentages (e.g., hospitalization rate) compared to averages (e.g., TCOC)
- Required inputs include estimated prevalence, acceptable margin of error, and confidence levels

2 Approach to determining minimum sample sizes

Percentages[1]	Minimum sample size $= \frac{[p*(1-p)*z^2]}{[MoE]^2}$
Averages[2]	Minimum sample size $= \frac{[s*z]}{[MoE]^2}$
Key	▪ p = prevalence ▪ z = statistic corresponding to confidence level (e.g. 2.57 for 99% confidence, 1.96 for 95%, 1.65 for 90%, 1.28 for 80%) ▪ MoE = acceptable margin of error ▪ s = historical standard deviation
Examples	▪ **Hospitalizations:** (11% hospitalizations * (1-11%)*1.65 (90% confidence)^2/(2% margin of error)^2 = 687 minimum sample size ▪ **Readmissions:** (26% readmissions* (1-26%)*1.65 (90% confidence)^2/(2% margin of error)^2 = 1,310 minimum sample size ▪ **ED utilization:** (14% ED utilization * (1-14%)*1.65 (90% confidence)^2/(2% margin of error)^2 = 810 minimum sample size

1 Inverted binomial test
2 Inverted T test

Source: CDC, AHRQ

Context for determining baseline for performance improvement measurement

Proposed approach to ensure fairness to practices and minimize impact of random variation

- Compare year of performance after passing Gate 2 to average 2-year baseline
  - Enhances robustness of historical experience
- Improvement expectations, while compounded annually, (e.g. 50% gap closure on process measures based on 2 year baseline), will be assessed based on total experience and need not occur in most recent year
  - Practice at 10th percentile needs to get to 40th percentile can get to 45th in year 1 and fall back to 40th percentile in year 2 but still pass Gate 3 due to overall performance improvement
- 50th percentile remains at baseline assessment and is published to make expectations clear to practices

Gate of entry	Implications
Gate 1	Performance in years 0-2 assessed relative to years -2 to 0
Gate 2	Performance in year 0-1 assessed relative to years -2 to 0
Gate 3	Direct Gate 3 entry will require existing performance to already exceed 50th percentile on 2/3 measures