NEW YORK STATE OF OPPORTUNITY. Department of Health

# Integrated Care Workgroup #13

March 8th, Empire State Plaza

# Proposed ICWG 13 Agenda

| Timing | Topic | Lead |
|---|---|---|
| 10:00-10:30am | Welcome / Updates on APC publications | ▪ Foster Gesten, Susan Stuard |
| 10:30-10:45am | DFS Update | ▪ John Powell |
| 10:45-11:30am | APC Model for 2017<br>▪ Structural & Performance Milestones | ▪ Marcus Friedrich<br>▪ Lori Kicinski |
| 11:30-12:00pm | Independent Validation Agent | ▪ Susan Stuard/Hope Plavin |
| 12:00-12:15pm | Working lunch | |
| 12:15-1:00pm | APC/CMS Score Card Alignment | ▪ Anne-Marie Audet/OMH |
| 1:00-1:10pm | IPRO Score Card Update | ▪ Anne Schettine |
| 1:10-1:45pm | SIM/TCPI/DSRIP Alignment | ▪ Hope Plavin<br>▪ Thomas Mahoney<br>▪ Alda Osinaga |
| 1:45-2:00pm | Closing | ▪ Foster Gesten |

# DFS Update

# DFS Update

- APC Payer Information Request
  - Responses due 18 March 2016
  - Additional Question and Answer teleconference on 8 March at 4:00pm
  - NEBGH multi-payer meeting on 15 March
  - Memorandum of Understanding (MOU)
    - Colorado multi-payer alignment example

# APC Model for 2017

# Milestones to satisfy all three requirements

- Does it improve patient care and promote outcomes that matter to patients and families?
- Is it meaningful for the practice and providers?
- Are payers willing to support it?

# The Journey to Completion for APC Milestone Specifications


- Result from more than a year of thinking across a wide range of stakeholders
- Represent the collective guidance of a range of experts
- Build on the experience of what works in other primary care programs and discard what does not
- 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

DRAFT

| | Commitment<br>Gate 1<br>*What a practice achieves on its own, before any TA or multi-payer financial support* | Readiness for care coordination<br>Gate 2<br>*What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet* | Demonstrated APC Capabilities<br>Gate 3<br>*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 …** | **Prior milestones, plus …** |
| **Participation** | i. APC participation agreement<br>ii. Early change plan based APC questionnaire<br>iii. Designated change agent / practice leaders<br>iv. Participation in TA Entity APC orientation<br>v. Commitment to achieve gate 2 milestones in 1 year | i. Participation in TA Entity activities and learning (if electing support) | |
| **Patient-centered care** | i. Process for Advanced Directive discussions with all patients | i. Advanced Directive discussions with all patients >65<br>ii. Plan for patient engagement and integration into workflows within one year | i. Advanced Directives shared across medical neighborhood, where feasible<br>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 local and county health collaborative Prevention Agenda activities<br>ii. Annual identification and reach-out to patients due for preventative or chronic care management<br>iii. Process to refer to structured health education programs |
| **Care Manage-ment/ Coord.** | i. Commitment to developing care plans in concert with patient preferences and goals<br>ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year | i. Identify and empanel highest-risk patients for CM/CC<br>ii. Process in place for Care Plan development<br>iii. Plan to deliver CM / CC to highest-risk patients within one year<br>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)<br>ii. Care plans developed in concert with patient preferences and goals<br>iii. CM delivered to highest-risk patients<br>iv. Referral tracking system in place<br>v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions<br>vi. Post-discharge follow-up process<br>vii. Behavioral health: Coordinated care management for behavioral health |
| **Access to care** | i. 24/7 access to a provider | i. Same-day appointments<br>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<br>ii. Certified technology for information exchange available in practice for<br>iii. Attestation to connect to HIE in 1 year | i. 24/7 remote access to Health IT<br>ii. Secure electronic provider-patient messaging<br>iii. Enhanced Quality Improvement including CDS<br>iv. Certified Health IT for quality improvement, information exchange<br>v. Connection to local HIE QE<br>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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# Collective feedback that refined the structural Milestones

| | |
|---|---|
| **Ease the burden of documentation** | Reduced required logs/screenshots, replaced with meaningful measures and improvement of those measures |
| **Align reporting criteria with NCQA, MU, and other initiatives** | Will develop a separate document to crosswalk APC between the different initiatives |
| **Strengthen Patient Engagement and Prevention Agenda Activities** | Linking milestones to community based services, used shared decision making tools |
| **High Risk Care Management delivery** | Using collaborative resources (community/ payer) and payer driven data |
| **Operationalize BH in a primary care setting** | Used the proposed BH framework that includes training, screening, integrated delivery of care |
| **Incorporate general bi-directional communication across Milestones** | Incorporate communication between providers, patients, community resources into the milestones |
| **Strengthen outcome and performance for Population Health, Care Management, Access and HIT** | Using outcome based measures at Gates 2 and 3 to improve performance |
| **Guidance instead of mandated requirements** | Acknowledgement of improvement and control of performance by practice and TA vendors |
| **Incorporate cultural competencies into Milestones** | Eliminated barriers in cultural and operational areas to reduce disparity and improve access |

# Next Steps:

- Incorporate Core Measures into Milestone Specifications
- Complete the Implementation and Milestone Reporting Guide
- Evaluate Gating criteria for alignment with other initiatives, including areas of potential ‘auto-credit’ and pre-validation

## Comments?

## Questions?

# Independent Validation Agent

# Independent Validation Agent - Workgroup Input

The practice transformation RFP will be issued shortly

A next step is to move forward with design for the Independent Validation Agent (IVA) – this will ultimately result in an RFP

- *Note*: new title of Independent Validation Agent – had previously referred to as oversight entity

Reviewed a basic outline at January ICWG meeting and will revisit today and garner input

Balancing act:

- Funding is limited, so need to get best bang-for-our buck
- Payers need to feel that verification meets their needs
- Practices need not be overwhelmed with documentation and audit

# Trust But Verify – The APC Model

NYS APC program creates a new environment where “trust but verify” is possible:

- APC identifies a core set of milestones, gates, and measures common across payers and providers
- NYS involvement sets the stage for aligned incentives for providers, payers and consumers
- Core measure set will enable verification and promote quality improvement at the practice level, across all payers, and will provide consistent information to both payers and providers

# IVA Role in Reliability and Alignment

Reliable Information: The IVA will audit *both* practices and TA entities participating in NYS's APC program to ensure consistency across regions and application of a single state-wide standard for achievement of gates and milestones.

- The audit function creates a trusted, independent, third-party review of practice achievements in the APC program and TA performance in support of these practice achievements.

Alignment of Payment Models: The IVA's verification and audit provides unbiased information about practice capabilities and eligibility for value-based payments for both commercial and government payers

# IVA: Key Activities

| Independent Validation Agent Activities | |
|---|---|
| **Activity** | **Notes** |
| Documentation Portal | • Develop and implement a portal for practice and TA entity submission of gate and milestone documentation<br>• Specific role-based access for practices, TA entities, payers, NYS DOH, and IVA entity |
| Review of Gate Assessments | • IVA to review documentation related to TA entity gate assessments for *a substantial sample of each TA's activity in each region*<br>• Establish standards for validity and reliability of assessments; findings used to educate TA entities and as input to audit plan |

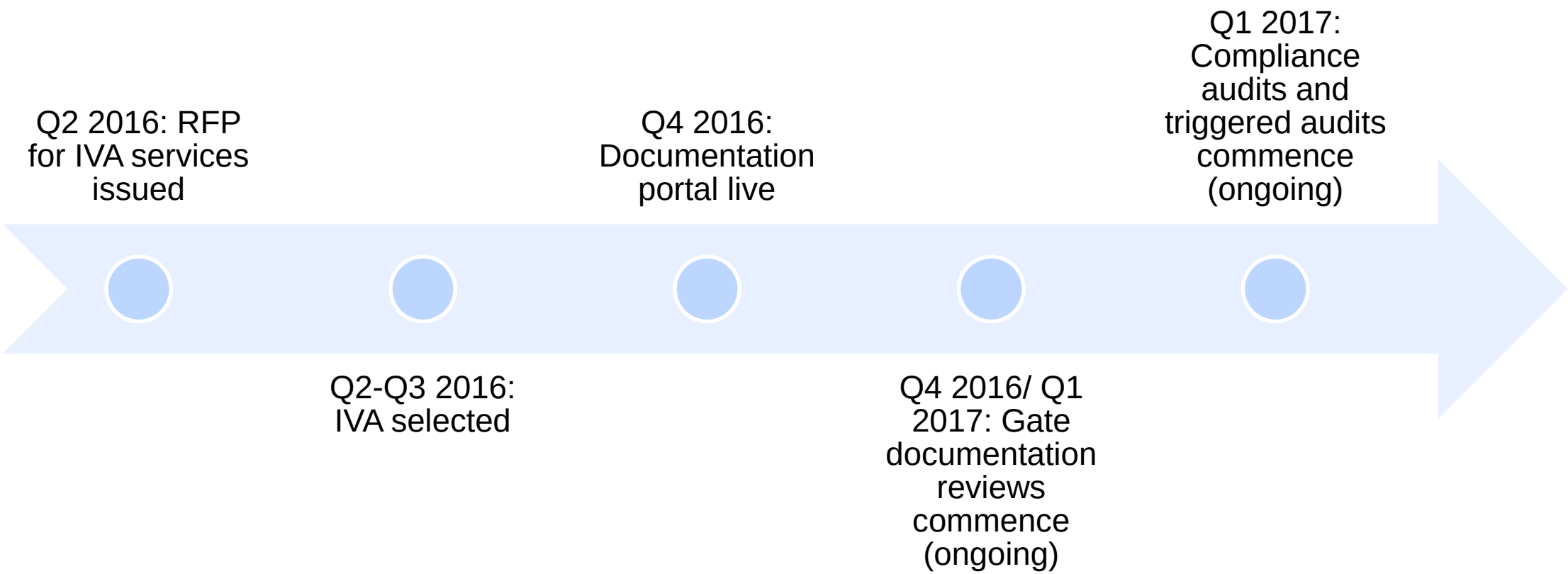
## Independent Validation Agent Activities

| Activity | Notes |
|---|---|
| Audit Plan for Compliance and Trigger Audits | • IVA to develop a detailed audit plan for compliance audits and triggered audits for both practices and TA entities<br>• Includes education and communication activities for practices and TA entities about audit process |
| Compliance Audits: Practices and TA Entities | • Practices and TA entities randomly selected for compliance audit.<br>• *Proposing approximately 60 compliance audits per year*<br>• Compliance audits via phone and documentation review<br>• Includes reporting and follow-up activities after failed audits |
| Triggered Audits: Practices and TA Entities | • Practices & TA entities selected using defined triggers in audit plan<br>• *Proposing approximately 60 triggered audits per year; perhaps ability to roll-over slots to compliance audits*<br>•Triggered audits conducted in person<br>• Includes reporting and follow-up activities after failed audits |

# IVA: Key Activities

| Independent Validation Agent Activities | |
|---|---|
| **Activity** | **Notes** |
| Survey of Practice Satisfaction with TA | • Administer electronic survey approved by NYS DOH to assess practice satisfaction with its TA entity |
| Project Management | • Regular project meetings with NYS DOH<br>• Monthly reports, six-month TA entity assessment, ongoing audit finding reports |

# High-Level Timeline: IVA Activities



# Working Lunch

# APC/CMS Score Card Alignment

# February 2016 Release by CMS of a Primary Care Measure set:

# What are the implications for the APC Measure Set?

- CMS Set Created by *Core Quality Measures Collaborative*: CMS, AHIP, NCQA, and several physician organizations (AAFP, ACC, ACP, AMA, CMSS)

- Core measure sets for seven areas of practice:
  1. **ACO/PCMH/Primary Care**
  2. Cardiology
  3. Gastroenterology
  4. HIV/Hepatitis C
  5. Medical Oncology
  6. Obstetrics and Gynecology
  7. Orthopedics

- AAP is planning to develop a pediatric core measure set

# CMS Primary Care versus New York APC Measure Sets
# A Comparison

- Not too many differences, but the few need to be considered carefully
- Four key differences:

1. ***Age range*:** CMS does not include measures that address children and adolescents

2. ***Prevention*:** CMS more limited in this domain. Does not include chlamydia screening, influenza immunization, childhood immunization and fluoride varnish. Notably, chlamydia screening is in the CMS OB/GYN set.

3. ***Cancer screening*:** CMS is more comprehensive: includes breast cancer, cervical cancer, and non-recommended cervical cancer screening in adolescents females.

4. ***Behavioral health*:**
   - CMS does not include a measure of alcohol and substance use.
   - Depression: each set includes 2 measures, they are both different
     - APC includes clinical depression screening/follow-up and antidepressant medication management.
     - CMS includes measures of outcomes: depression remission and response at 12 months.

# Other differences – CMS includes the following process measures not included in APC Set:

- Four diabetes measures (other than HbA1c control):
  - Comprehensive Diabetes Care: HbA1C Testing*
  - Comprehensive Diabetes Care: Eye Exam *
  - Comprehensive Diabetes Care: Foot Exam
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy*

  *The *HbA1C Testing*, *Eye Exam*, and *Nephropathy* measures are already under consideration as version 1 (only) measures in the APC set.

- One chronic care measure:
  - Persistent Beta Blocker Treatment after Heart Attack

# Aligning APC to CMS Measure Set Summary: Measures in green (found in CMS set only) would be added and the measures in red (found in APC only) would be removed.

| Domains | NQF #/HEDIS | Measures |
|---|---|---|
| Prevention | 32 | Cervical Cancer Screening |
| | --/HEDIS | Non-recommended Cervical Cancer Screening in Adolescent Females |
| | 2372/HEDIS | Breast Cancer Screening |
| | 34/HEDIS | Colorectal Cancer Screening |
| | 33/HEDIS | Chlamydia Screening |
| | 41/AMA | Influenza Immunization - all ages |
| | 38/HEDIS | Childhood Immunization (status) |
| | 2528/ADA | Fluoride Varnish Application |
| Chronic Disease | 28/AMA | Tobacco Use Screening and Intervention |
| | 18/HEDIS | Controlling High Blood Pressure |
| | 59/HEDIS | Comprehensive Diabetes Care: HbA1C Poor Control |
| | 57/HEDIS | Comprehensive Diabetes Care: HbA1C Testing (currently proposed for version 1 of APC only) |
| | 55/HEDIS | Comprehensive Diabetes Care: Eye Exam |
| | 56/HEDIS | Comprehensive Diabetes Care: Foot Exam (currently proposed for version 1 of APC only) |
| | 62/HEDIS | Comprehensive Diabetes Care: Medical Attention for Nephropathy (currently proposed for version 1 of APC only) |
| | 71/HEDIS | Persistent Beta Blocker Treatment after Heart Attack |
| | 1799/HEDIS | Medication Management for People With Asthma |
| | 24/HEDIS | [Combined obesity measure] Weight Assessment and Counseling for nutrition and physical activity for children and adolescents |
| | 421/CMS | [Combined obesity measure] Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up |
| Behavioral Health/ Substance Use | 418/CMS | Screening for Clinical Depression and Follow-up Plan |
| | 4/HEDIS | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |
| | 105/HEDIS | Antidepressant Medication Management (currently proposed for version 1 of APC only) |
| | 710/MCM | Depression Remission at 12 months |
| | 1885/MCM | Depression Response at 12 months – Progress towards Remission |
| Patient-Reported | 326/HEDIS | Advance Care Plan |
| | 5/AHRQ | CAHPS Access to Care, Getting Care Quickly |
| Appropriate Use | 52/HEDIS | Use of Imaging Studies for Low Back Pain |
| | 58/HEDIS | Avoidance of Antibiotic Treatment in adults with acute bronchitis |
| | --/HEDIS | Inpatient Hospital Utilization (HEDIS) |
| | 1768/HEDIS | All-Cause Readmissions |
| | --/HEDIS | Emergency Department Utilization |
| Cost | -- | Total Cost Per Member Per Month |

# For Discussion: Proposed Revised APC Straw Measure Set

Although alignment to a national set is the goal, in the near term, the NYS SIM goals also need to be considered in the selection of measures. The CMS set is an “initial set,” and like the APC set, will be updated and evolve in the future (not “set” in stone). Continued monitoring of the APC set through the SIM governance structure will be key to ensuring future alignment.

**Recommendations:**

- Retain APC child and prevention measures.
- Include four diabetes process measures – HbA1c testing, eye exams, foot exams, and nephropathy in v1.
- Do not include non-recommended cervical screening for adolescents.

**For further discussion:**

- Discuss additional cancer screening measures – breast and cervical.
- Persistent beta blocker treatment after heart attack.
- Behavioral health measures.

# Additional Information for Alignment Discussion

| Domains | Measures | Additional Information for Measure Alignment Discussion |
|---|---|---|
| Prevention | 1. Non-recommended Cervical Cancer Screening in Adolescent Females | ▪ Adolescent Measure, Overuse Measure<br>▪ NCQA/HEDIS, Not NQF endorsed, Collected in QARR<br>▪ [Commercial HMO] NY (4%); Natl (3%)<br>▪ [Commercial PPO] NY (6%); Natl (4%)<br>▪ [Medicaid Managed Care] NY (4%); Natl (4%)<br>Source: QARR, NYS DOH Health Plan Comparison in New York State Reports |
| | 2. Cervical Cancer Screening | ▪ [Commercial HMO] 2015: NY (80%); Natl (76%). 2010: NY (79%); Natl (77%)<br>▪ [Commercial PPO] 2015: NY (80%); Natl (74%). 2010: NY (76%); Natl (75%)<br>▪ [Medicaid Managed Care] 2015: NY (75%); Natl (60%). 2010: NY (73%); Natl (66%)<br>Source: QARR, NYS DOH Health Plan Comparison in New York State Reports |
| | 3. Breast Cancer Screening | ▪ [Commercial HMO] 2015: NY (74%); Natl (74%). 2010: NY (71%); Natl (71%)<br>▪ [Commercial PPO] 2015: NY (66%); Natl (70%). 2010: NY (67%); Natl (67%)<br>▪ [Medicaid Managed Care] 2015: NY (71%); Natl (59%). 2010: NY (68%); Natl (52%)<br>Source: QARR, NYS DOH Health Plan Comparison in New York State Reports |
| Chronic Disease | Persistent Beta Blocker Treatment after Heart Attack | ▪ Collected in QARR (no other major programs)<br>▪ [Commercial HMO]: 2015: NY (84%); Natl (84%). 2012: NY (76%); Natl (74%)<br>▪ [Commercial PPO]: 2015: NY (87%); Natl (82%). 2012: NY (76%); Natl (70%)<br>▪ [Medicaid Managed Care] 2015: NY (86%); Natl (83%). 2012: NY (81%); Natl (82%) - earliest available Medicaid data<br>Source: QARR, NYS DOH Health Plan Comparison in New York State Reports |
| Behavioral Health/ Substance Use | 1. Screening for Clinical Depression and Follow-up Plan | OMH-led Discussion |
| | 2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | OMH-led Discussion |
| | 3. Antidepressant Medication Management (proposed for version 1 of APC only) | OMH-led Discussion |
| | 4. Depression Remission at 12 months | OMH-led Discussion |
| | 5. Depression Response at 12 months – Progress towards Remission | OMH-led Discussion |

# Deep Dive on APC vs CMS Behavioral Health Measures

| Measure Set | Behavioral Health Measure | NQF/HEDIS | Domain | Programs |
|---|---|---|---|---|
| APC | **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** | 4/HEDIS | Substance Use | APC, QARR, DSRIP, MU, PQRS, Medicaid Adult Core Set, MSSP, CPC, NY Prevention Agenda |
| APC | **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan** | 418/CMS | Depression Screening and Follow-up | APC, DSRIP, MU, PQRS, Medicaid Adult Core (18 years+), MSSP, CPC, NY Prevention Agenda |
| APC/Version 1 | **Antidepressant Medication Management** | 105/HEDIS | Depression Medication | APC, QARR, DSRIP, Medicaid Adult Core, CPR Employer-Purchaser Priority Set |
| CMS PCMH | **Depression Response at 12 months** | 710/MN Community Measurement | Depression Outcome | CMS PCMH, MU, PQRS, States: CT, MN |
| CMS PCMH | **Depression Response at 12 months – Progress towards Remission** | 1885/MN Community Measurement | Depression Outcome | CMS PCMH Measure Set |

- **HEDIS depression measures (with shorter follow-up periods than those in CMS PCMH set):**
  - *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults*: The percentage of members age ≥12 with a diagnosis of major depressive disorder or dysthymia who had a PHQ-9 or PHQ-A tool administered at least once during a 4 month period.
  - *Depression Remission or Response for Adolescents and Adults:* The percentage of members 12 years of age and older with a diagnosis of major depressive disorder or dysthymia and an elevated PHQ-9 or PHQ-A score, who had evidence of response or remission within 5–7 months of the elevated PHQ-9 score

# IPRO Score Card Update

# IPRO's Role in APC Scorecard V1.0

## Data Aggregation

- Pre-pilot phase – payer survey and interview
  Information gathering about engagement, ability to provide data, and current methods used in provider reports

- Pilot phase – test files for a smaller number of payers
  Information about volume of practices and members, ability to aggregate practices

- Post-pilot phase – data validation
  Exploration of validity measure results with practices and issues with patient-to-provider and provider-to-practice attribution

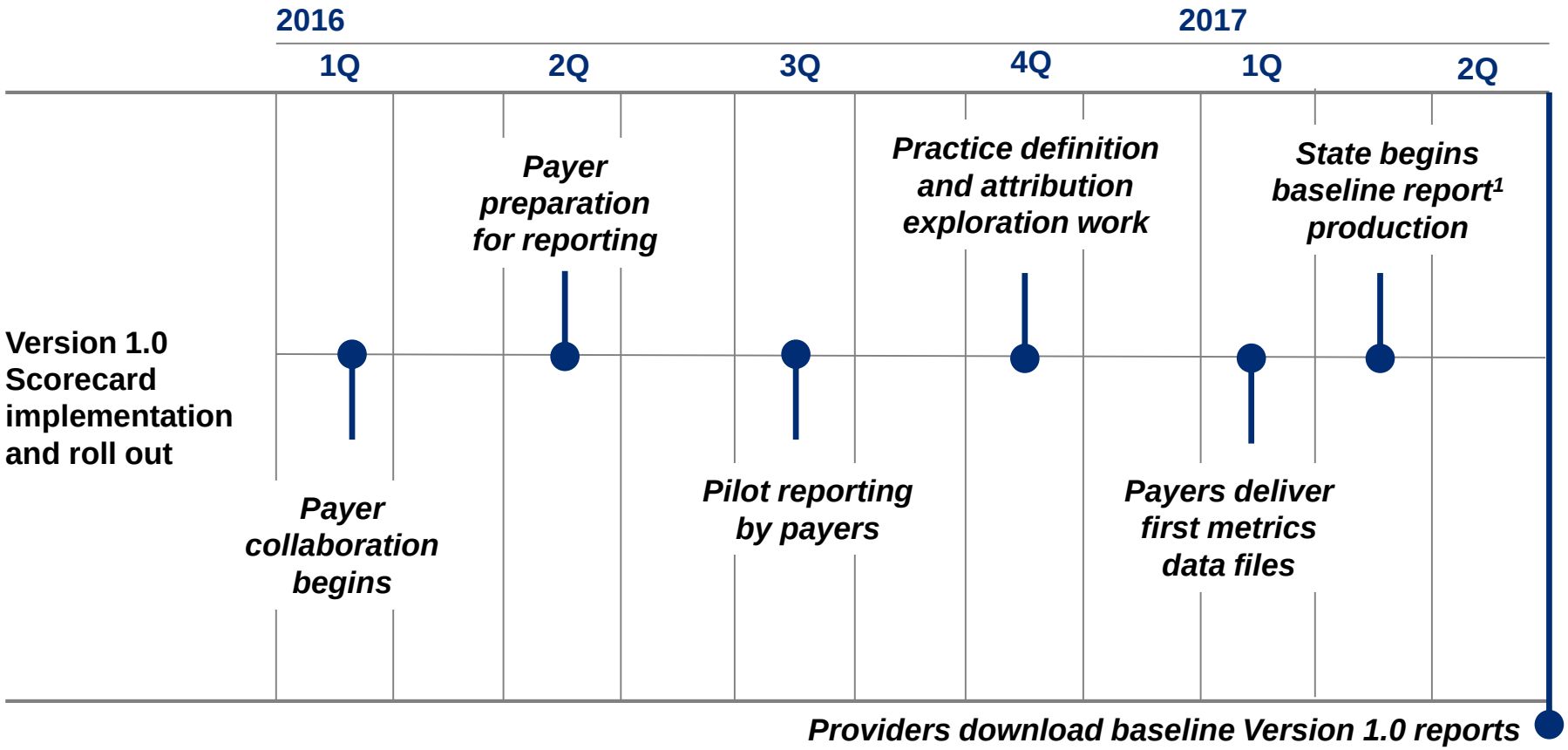
## Technical Assistance

- Non-HEDIS measures

- Payers with file creation and submission

- Practices and Payer questions about aggregated results

# Version 1.0 launch is planned for January 2017




[1] *Baseline reports are based on recent 12-month performance*

# SIM/TCPI/DSRIP Alignment

# Alignment: Our Ask of Key Stakeholders

- 3 sources of practice transformation support
- Each initiative has a unique character...but similar if not the same ultimate goal - to ready practices for a world of value based payment
- Where we can, we will align ( for ex. Measures)
- We need your help to share information and promote understanding

# Practice Transformation in New York State: SIM, DSRIP, TCPI - One Common Goal:

"*To transform primary care practices to be ready to practice team based care, use electronic health information and participate in value based payment models including shared savings*"

Alignment is necessary to achieve common goal(s):

- Model
- Measures and
- Payment

# SIM, DSRIP, TCPI

1. The Delivery System Reform Incentive Payment (DSRIP) program

*Under New York's DSRIP program, Performing Provider Systems (PPSs) are incented to use some of the funds they have received to support practice transformation (to NCQA's PCMH-14 model, or the state-developed APC model) for the primary care practices in their respective networks. DSRIP's prime focus is on safety-net providers, but the PPS networks include both safety-net providers (more than 30% of whose patient panels are uninsured or covered by Medicaid) and those practices serving more Medicare and commercially-insured populations.*

2. The State Innovation Model (SIM) (Advanced Primary Care)

*NYS will implement a statewide program of regionally-based primary care practice transformation to help practices across NYS adopt and use the Advanced Primary Care (APC) model, with the goal of expanding the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020.*

3. The Transforming Clinical Practice Initiative (TCPI) program

*New York State's Practice Transformation Networks have committed to helping clinicians to develop strategies that will position them for coming value based payment models.*

# Key Areas of Alignment

| DSRIP | SIM | TCPI |
|---|---|---|
| **Focus:** Primary care practices participating in PPS provider networks - required to achieve Level 3 PCMH (2014) or APC, by March 2018. | **Focus:** Primary care practices: Implementation 2017 | **Focus:** Clinician practices, both primary care and specialty |
| **Who provides funding/support to the provider:** The PPS in relevant DSRIP projects. | **Who provides funding/support to the provider:** APC Technical assistance (TA) vendors. | **Who provides funding/support to the provider:** 3 TCPI funded grantees –<br>• Care Transitions Network for People with Serious Mental Illness<br>• Greater New York City Practice Transformation Network<br>• New York State Practice Transformation Network |
| **Resources/Payment:** Practices are supported by PPSs to reach PCMH or APC designation through TA contracts or centralized resources. | **Resources/Payment:** TA vendor paid on a per-practice basis. Focus on smaller practices. | **Payment:** TA vendors paid on a per-provider basis – Focus on larger practices. |

# Key Areas of Alignment

- Core competencies
- Milestones defining practice/provider capabilities
- Curriculum
- Practice assessment tools
- Measures/KPIs
- Tracking/reporting
- Oversight by independent third party to review practice competencies for purposes of payment – commercial and public.

## NYS Practice Transformation Initiatives Under Way
## Program Focus, Inclusion and Exclusion Criteria

| | TCPI - Practice Transformation Network Program (PTN) | | | SIM - APC | DSRIP |
|---|---|---|---|---|---|
| | NYSPTN | NYU PTN | National Council for Behavioral Health | | |
| **Program Focus** | Primary Care and Certain Specialty Practices | Primary Care and Certain Specialty Practices | Behavioral Health Providers Serving the Seriously Mentally Ill | Primary Care Practices | Primary Care Practices Participating in PPS |
| **Geographic Focus** | Statewide | Brooklyn | Statewide | Statewide | Statewide |
| **Overall Exclusions: Practices served by / Currently enrolled in Other CMMI-Funded Practice Transformation Programs** | | | | | |
| Medicare Shared Savings Program, Pioneer ACO | Excluded | Excluded | Excluded | Eligible | Eligible |
| Multi-Payer Advanced Primary Care Program (MAP-CP) | Excluded | Excluded | Excluded | Excluded | Eligible |
| Comprehensive Primary Care Initiative (CPCi) | Excluded | Excluded | Excluded | Excluded | Eligible |
| FLHSA CMMI HCIA project | Excluded | Excluded | Excluded | Excluded | Eligible |
| **TCPI Cross-Program Interaction** | | | | | |
| **Practices Receiving Practice Transformation Support Under** | **TCPI - Practice Transformation Network Program** | | | **SIM - APC** | **DSRIP** |
| | **NYSPTN** | **NYU PTN** | **National Council for Behavioral Health** | | |
| **NYSPTN** | | Excluded | Excluded | Excluded | Eligible * |
| **NYU PTN** | Excluded | | Excluded | Excluded | Potentially Eligible |
| **National Council for Behavioral Health** | Excluded | Excluded | | Excluded | Potentially Eligible |
| **SIM / APC** | Excluded | Excluded | Excluded | | Excluded |
| **DSRIP - PPS** | Eligible * | Potentially Eligible | Potentially Eligible | Excluded | |

*Primary care practices in PPSs **may** be eligible for practice transformation support from NYSPTN, with priority given to PPSs that invest in related capacities in those practices

## Comments?

## Questions?

# Closing