NEW YORK STATE OF OPPORTUNITY. Department of Health

Integrated Care Workgroup

May 9, 2016

NEW YORK STATE Department of Health Innovation Center

Integrated Care Updates - webinar agenda

Timing	Topic	Lead
10:00 – 10:15	Welcome & Roll Call	Foster Gesten/Marcus Friedrich
10:15 – 10:30	NEBGH Update on Payer Advisory Council	Amy Tippett-Stangler
10:30 – 11:15	DFS Support of APC Investments	John Powell
11:15 – 11:45	Next Steps post RFI: • 1:1 Plan Meetings • MOU Development	John Powell/Susan Stuard
11:45 – 12:00	CPC+ Update and Crosswalk	Marcus Friedrich/Lori Kicinski
12:00 – 12:15	Consumer Engagement Update	Stefanie Pawluk
12:15 – 12:30	Closing Remarks	Foster Gesten/Marcus Friedrich

Northeast Business Group on Health Payer Advisory Council Update

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SIM Purchaser Advisory Council (PAC) Members

20 members

Key Themes from SIM PAC

- "Even if APC is cost neutral down the road, if employees get better care, it's okay."
- Physician and patient attribution methodologies are critical to the success of APC and calculating the ROI
- Agreement on the importance of educating members/patients about the PCMH/APC designated practices; benefit design can be used to help direct patients
- They have invested in many other initiatives that did not result in an ROI and are willing to support an initiative like SIM/APC with a focus on delivering value and better care to employees
- Employers would like the opportunity to have an open discussion with the health plans at the table to let them know that they are open to being on board
    - Next SIM PAC meeting is on June 30th

DFS Support of APC Investments

Goals & Objectives of RFI

- To better understand current and evolving primary care delivery and payment models
- To have a basis on which to assess degree or extent of change that might be required to ensure alignment needed to create systemic efficiencies
- To define “what counts” for purposes of rate relief
- To evaluate specific regions of the state most appropriate for practice transformation investments to ensure long-term sustainability

Responses Received and Limitations

- **12 plans** responded to RFI (n=12 for this summary)
  - The survey was sent to 18 plans, including NYS Public Health Plans **(PHSPs, indicated by asterisk)** to provide them the opportunity to respond. Because of their lines of business, we understand this RFI may not have been applicable or they may have been completing the Medicaid VBP survey.
  - Responses were voluntary
  - Some declined due to smaller commercial LOBs, or have a majority of Medicaid business and were responding to Medicaid VBP survey; another respondent contracts its primary care network and declined to respond; it is possible that two other plans will submit responses soon
  - Plans were asked to provide information on both commercial and Medicare Advantage lines of business.
  - One plan included in this summary is an ASO; for purposes of this summary their findings were accounted for in all “commercial” sections that follow
  - Responses varied in level of detail and completion; follow up will continue to better inform these summary findings

Responded	Did not respond/declined
1. Aetna	1. Affinity*
2. CDPHP	2. Cigna
3. Emblem	3. Fidelis*
4. Empire BCBS	4. Metroplus*
5. Excellus	5. Care Connect (North Shore LIJ)
6. Health First*	6. Oscar
7. Health Now	
8. Independent Health	
9. MVP Health Care	
10. United Healthcare	
11. United Healthcare – NYS Empire Plan	
12. Wellcare	

Delivery of High Value Care

Finding 1: Extensive work is ongoing to incent and realize delivery of high value care

100% of plans reported having contracts inclusive of primary care models that support team based care. Penetration and investment in these models varied widely.

- **100%** of plans responding to the RFI reported offering *at least one* alternative or outcome based program
- **92%** of the plans responding to the RFI indicated that they provide Practice Transformation (PT) support
- Of the plans providing PT support, **91%** clearly indicated they provide financial support to practices (which may include a stipend or PMPM)

-Alternative or outcome based programs are broadly defined and include anything more than "plain FFS" including P4P programs, FFS with link to quality, quality bonus programs, etc.

-Practice Transformation, for purposes of this summary, is broadly defined as support that may be financial, services, technology, staff, etc.

Variation in Practice Transformation Support to Providers

- **92%** of the plans responding to the RFI indicated that they provide Practice Transformation (PT) support
  - Of the plans providing PT support, **91%** clearly indicated they provide financial support to practices (which may include a stipend or PMPM
- Other in-kind support and investments vary but include the following examples

Data and analytics	Care management tools	Funding for EHR, regional HIE and meaningful use
Daily and monthly practice data	Communications tool kits	Stipend to support time away from the practice
Dashboards and dashboard tools	Medication reconciliation	PMPM fees paid to groups and to develop systems and infrastructure need to coordinate care

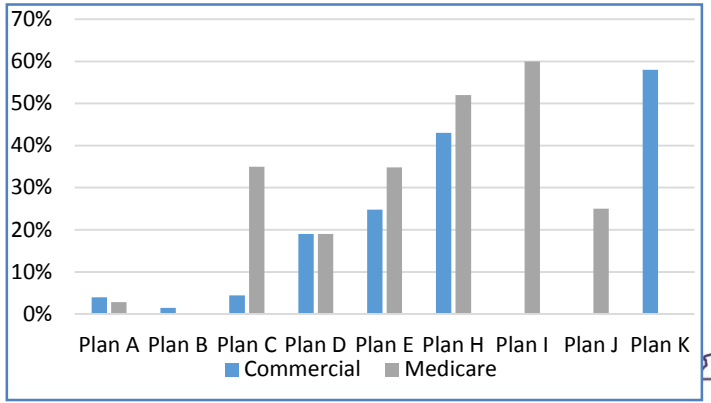
Investment in Value-Based Primary Care Programs

- Investment in value-based programs as a proportion of total spend varied widely across the plans, but **none** reported higher than 75% of their spend as supporting value-based programs.
- However, many plans indicated goals of more than 75% of their spend or membership as being covered in a value-based model over the next few years.
- Of the plans that did report what percent of their spend supports value-based primary care programs, the following breakdown was compiled.

Chart 1: Value-based primary care programs as a percent of commercial and Medicare Advantage (MA) spend

Range of spend	# of plans	% of plans
0-25% of commercial spend	4	44%
26-50% of commercial spend	3	33%
51-75% of commercial spend	2	22%
76-100% of commercial spend	0	0%
Range of spend	# of plans	% of plans
0-25% of MA spend	3	43%
26-50% of MA spend	2	29%
51-75% of MA spend	2	29%
76-100% of MA spend	0	0%

Graph 1: Value-based primary care programs as a percent of commercial and Medicare Advantage (MA) spend



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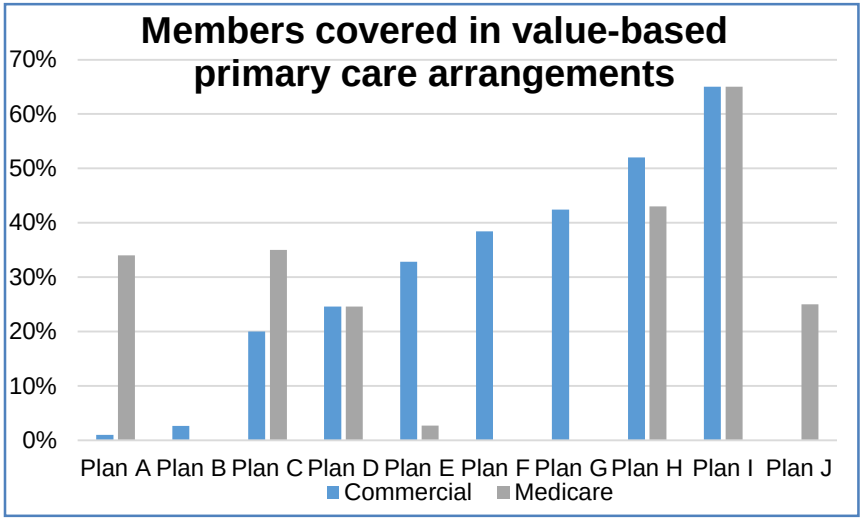
Penetration of Value-Based Models: Membership

Finding 2: The reach of value based programs is widely varied; there are opportunities to impact more members and primary care providers in plan networks.

Of plans providing information on what percent of members are covered in a value-based primary care arrangement, by commercial and/or Medicare Advantage line of business, the below information was compiled.



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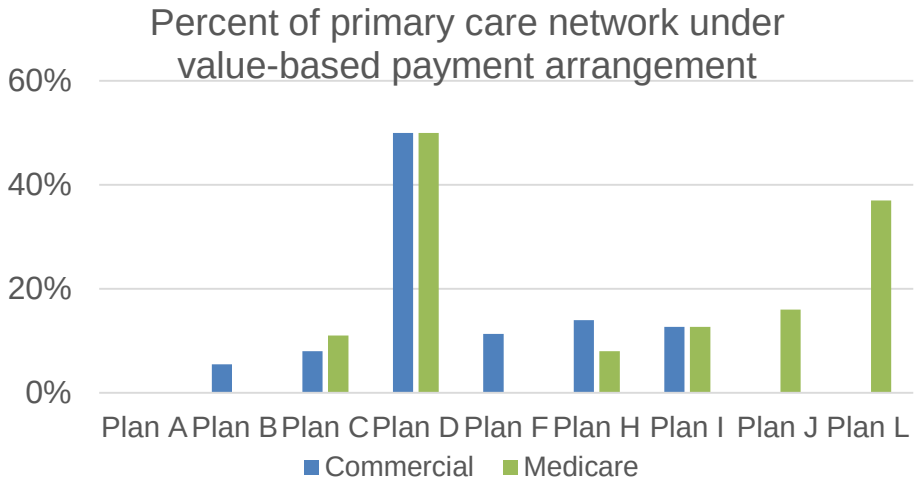
Penetration of Value-Based Models: Primary Care Networks

Of the health plans providing information on what percent of their primary care networks are in a value-based payment contract, the following ranges were compiled.



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APC Alignment

Finding 3: Many plans believe current programs are aligned with APC or are ready to implement APC in their networks by 2018; however, several plans need further information on the business case for APC before committing to adoption at this time.

Plans were asked to indicate their readiness to implement APC in their networks. Some plans provided timelines and comments that they believe their program(s) fit the current APC model (or that it may with the addition of aligned quality measures). For the below chart on readiness, some plans may have provided more than one answer.

Chart 4: Readiness for APC (more than one answer may have been provided; n=13)

Readiness for APC	# of plans	% of plans
Current programs meet requirements; thinks current program counts as APC	4	31%
Ready to implement in 2017	3	23%
Ready to implement in 2018	1	8%
Will consider but no timeline provided	1	8%
Not enough information provided	1	8%
Declining to commit	3	23%

APC Rate Review Proposal

- To recognize insurers' PT and CC payments, DFS will adjust the pricing medical loss ratio formula (MLR) for prior approval rate applications for 2017 premium rates.

$$\text{Current MLR} = \frac{\text{Claims}}{\text{Premiums}} \qquad \textbf{New MLR} = \frac{\text{Claims + PT payments + CC Payments}}{\text{Premiums}}$$

- Insurers should therefore calculate the ratio of (1) the total projected PT and CC payments for 2017, to (2) the total projected premiums for 2017. The insurer should then add that percentage to the 2017 pricing MLR in their rate adjustment filing. For instance, if projected PT and CC payments are 0.4% of 2017 projected premiums, the pricing MLR should be 0.4% higher than it would have otherwise been.

Next Steps

Some Important Next Steps with Payers

- Individual plan follow up:
  - Clarify answers to questions that were unclear or unanswered
  - Discuss and formalize commitment to future/planned VBP with primary care network
  - Create alignment with APC over time
  - Identify specific regions and practices with highest opportunity for multi-payer initiative
  - Discuss MOU and formal process of plan and provider commitment and engagement

Next Steps: Memorandum of Understanding (MOU)

- The purpose is:
  - To recognize those regions of New York State in which commercial plans are willing to work collaboratively to support practices that have, are and will transform to meet the guidelines and milestones of New York's Advanced Primary Care delivery model; and
  - To identify payers indicating a willingness to structure reimbursement for primary care that is consistent with the gates and milestones as defined in the NYS Advanced Primary Care model and that will in turn determine eligibility for available possible rate credits and MLR adjustments.
  - To demonstrate multi-payer commitment to encourage Medicare alignment with New York's Advanced Primary Care delivery model

APC/CPC+ Crosswalk

CPC+
Comprehensive Primary Care Plus (CPC+)

- 5 year, multi-payer care delivery initiative *and* alternative payment model (APM)

  (2017-2021)
- 20 regions nationally, up to 5,000 providers
- Strengthening primary care to reduce costs
- Aligns broadly with APC
- Preferences: 7 existing CPC Classic Regions, current/former MAPCP and SIM States with Medicaid participation

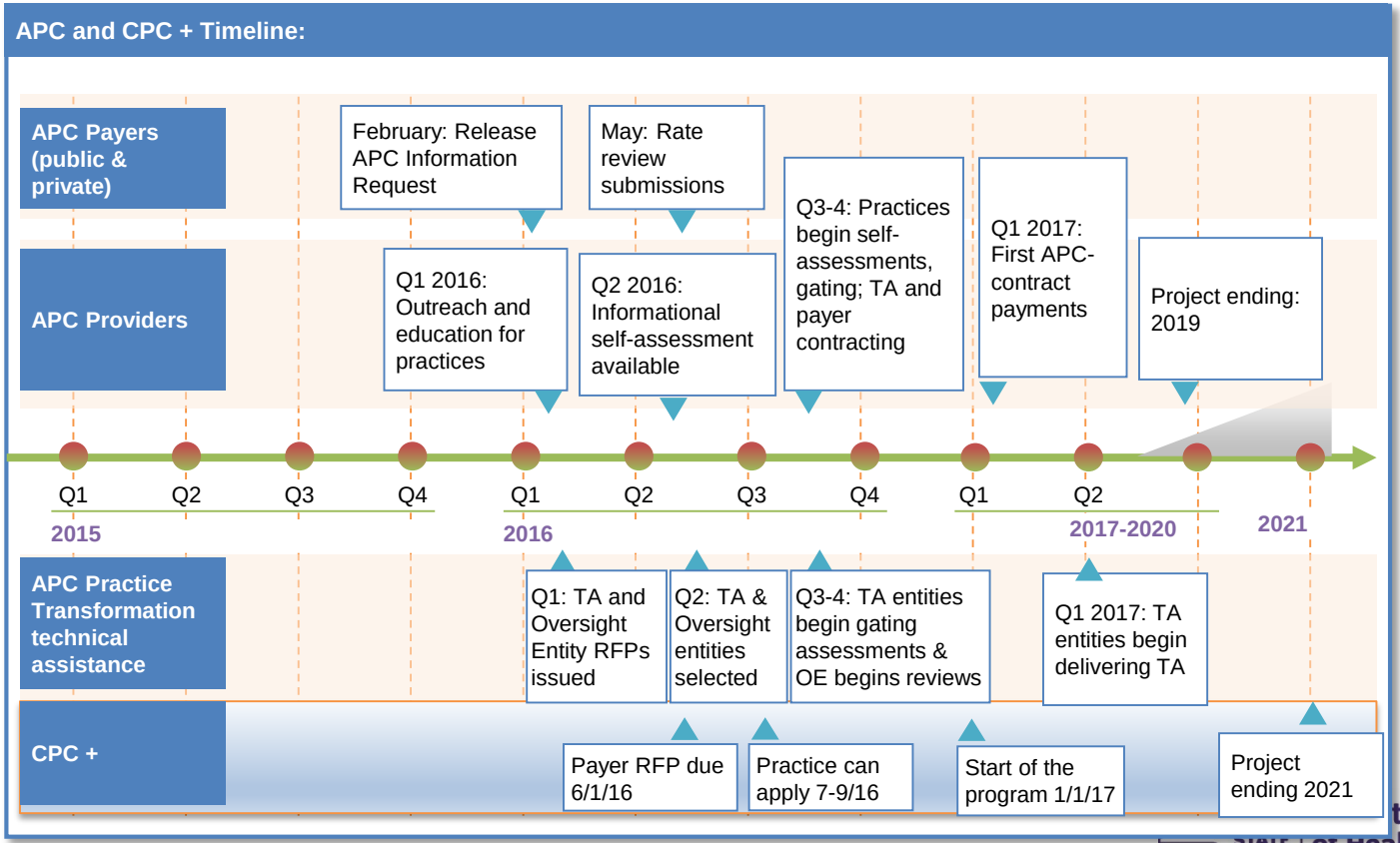
Possible APC and CPC+ alignment:

Areas	APC	CPC +
Primary care focused	✓	✓
Prospective transformation payments	✓	✓
Value based payment component	✓	✓
Milestones requirements over time	✓	✓
Set of core measures	✓	✓

APC and CPC+ alignment issues:

- Exclusion for Medicare ACO's and FQHC's
- Limited geographic regions
- Certified Health IT as a criteria for participating
- Core measures

APC and CPC + Timeline:



Consumer Engagement Update

Key Themes

- Critical to institutionalize consumers into the process to create demand for APC
- Need to identify the attributes of value for consumers to generate brand equity in APC
- Need to find ways to engage patients in their own care – identify the mechanisms and share best practices to avoid duplication of effort
  - Availability of a central resource for TA entities and providers
  - Availability of tools for patients to participate and advocate for themselves in their own care; how to use shared decision making tools, self-management tools

Comments & Suggestions

- Multiple initiatives occurring in NYS – want to ensure that efforts on state side are coordinated to engage consumer/patient input
- Ensure the right people are engaged and providing input in the process
- Explore Patient Centered Primary Care Collaborative TCPI Support and Alignment Network

Closing Remarks

Appendix

CPC+ and APC High-level Crosswalk Appendix

	CPC+	APC
Scope	• 7 Existing CPC Classic Regions with up to 13 new (incl. Capital District/ Mid-Hudson Region) for 5 year Model	• All NYS Regions through model completion: 1/2019
	• Preferences given to existing CPC regions, active multi-payer involvement, current/former MAPCP and SIM states with Medicaid participation	• No preferences given by NYS region, eligibility for completed Models such as PCMH, MAPCP, TCPI at Gate 2
	• Approx. 3.5M Medicare FFS lives + covered lives of other par payers	• Potential impact for 11.8 million NYS lives
	• Two tracks of increasing complexity/sophistication. Up to 5000 practices: Track 1(2500) Track 2 (2500)	• Potential impact of transformation for ~ 6000 primary care providers
	• Track 1: ~$15 PBPM/$2.50 opportunity Track 2: ~$28 PBPM/$4 opportunity	• Payer commitment to practice level transformation support (gate 1; care management /support Gate 2 and and VBP arrangements by Gate 3
Non-Medicare Payers	• Required performance-based incentives for both Tracks, and convert cash flow from FFS to APM for Track 2	• Potential APC alignment with existing/proposed value-based payment models
	• Provide regular practice and member level utilization/cost data & align quality/patient experience measures	• Commitment to align/deliver Core Measure data for aggregated reporting under V1 through launch of APD
	• Short window for application: now through June 1, 2016	• On-going 1:1 DOH/payer meetings, release of RFI and Q&A; possible MOU
Practice Eligibility	• Minimum of 150 Medicare beneficiaries, CEHRT health IT, MOU with HIT vendor and Medicare for Track 2. Other factors include system affiliations, geography, practice size • Application window: July – Sept 2016	• No minimum number of beneficiaries required • Health IT required for Gates 2, 3 • Rolling applications begin ~July 2016
Milestones & Functions	• 5 Milestone Functions: Access & Continuity, Care Management, Comprehensiveness & Coordination, Patient Caregiver Engagement, Planned Care & Population Health	• 7 Structural Milestones: Participation, Patient-Centered Care (NYS Prevention Agenda), Population Health, Care Management/ Coordination (including BH), Access to Care, HIT & Payment Model
Quality & Performance Measures	• 18 Quality Measures, 5 different domains, practices report subset quarterly • CMS to provide practice/member-level quarterly data: FFS cost/utilization, specialty/subspecialty care, ED/ hospitalization, other high cost services • CMS to execute transparency in practice reporting	• 28 Core Measures V1(18), 6 different domains, 13 aligned with CPC+ • V1 multi-payer aggregated claims-only quarterly reports to practices Q1, 2017 • Further reporting refinement expected in V2 and launch of APD in 2017

Aligning APC to CMS Measure Set Summary:

Measures in green (found in CMS set only). Measures in red (found in APC only).

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 (originally proposed for version 1 only)
	55/HEDIS	Comprehensive Diabetes Care: Eye Exam
	56/HEDIS	Comprehensive Diabetes Care: Foot Exam (originally proposed for version 1 only)
	62/HEDIS	Comprehensive Diabetes Care: Medical Attention for Nephropathy (originally proposed for version 1 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

New APC Set - with CMS/AHIP Alignment (added CMS measures in yellow)

28 measures total - 18 measures in Version 1 (claims-only measures)

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

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Forthcoming work: identify possibilities for alignment with the recently released CPC+ Core Measure Set (*yellow highlight*)

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

Principles Moving Forward for APC Core Measure Set

- **Use a phase-in approach to the APC Core Measure Set**
  - Start with a Version 1 that comprises claims-based measures that are easy to collect/report
  - Observe implementation of the APC Core Set and the CMS Primary Care Set over 18 months – payer and provider experiences will guide evolution, revisions and updates of the APC Core Set
  - Understand and facilitate APC providers' abilities to collect and report clinical measures (for Version 2)